

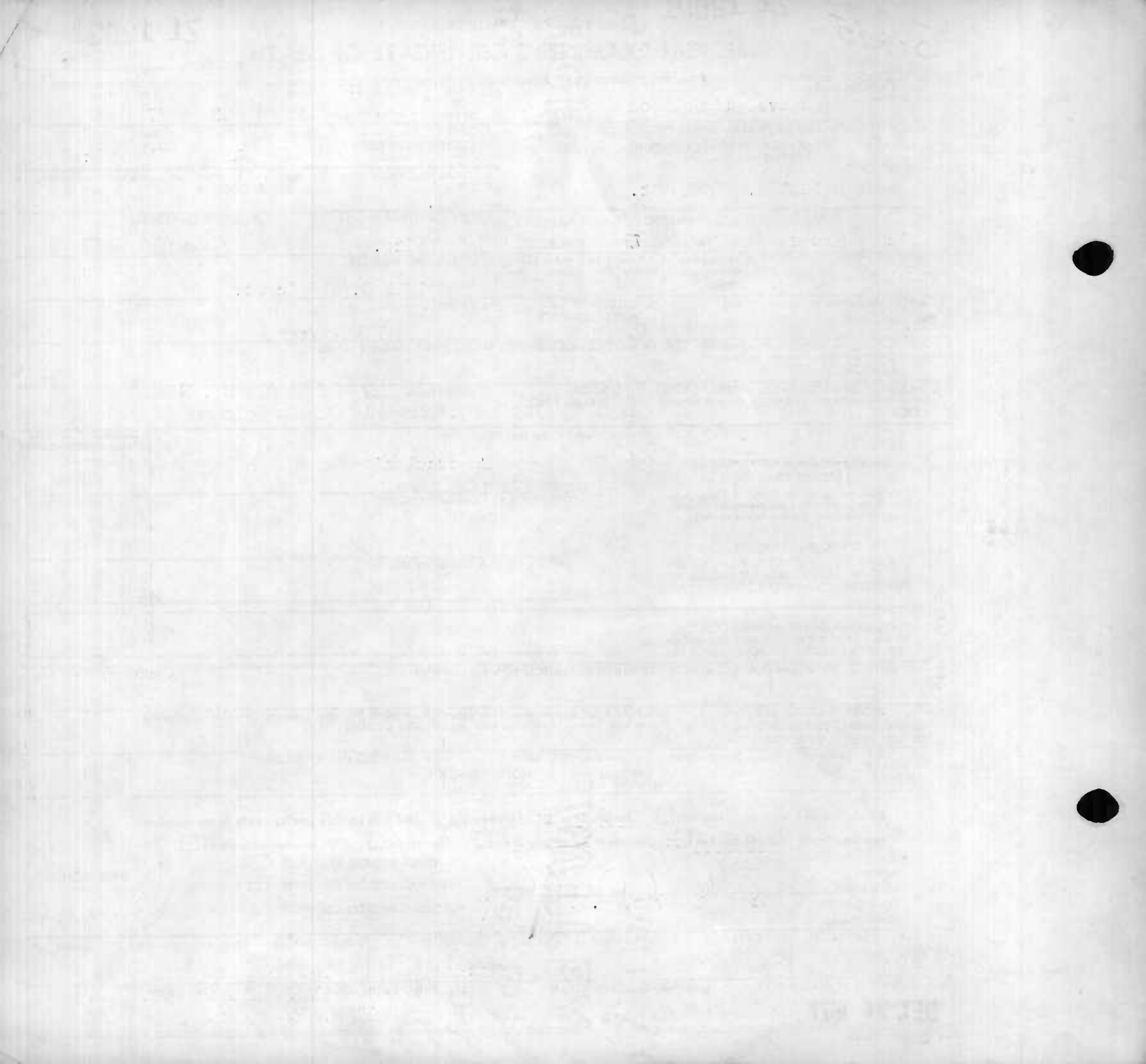
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12001

BIRTH NO.

REG. NO.

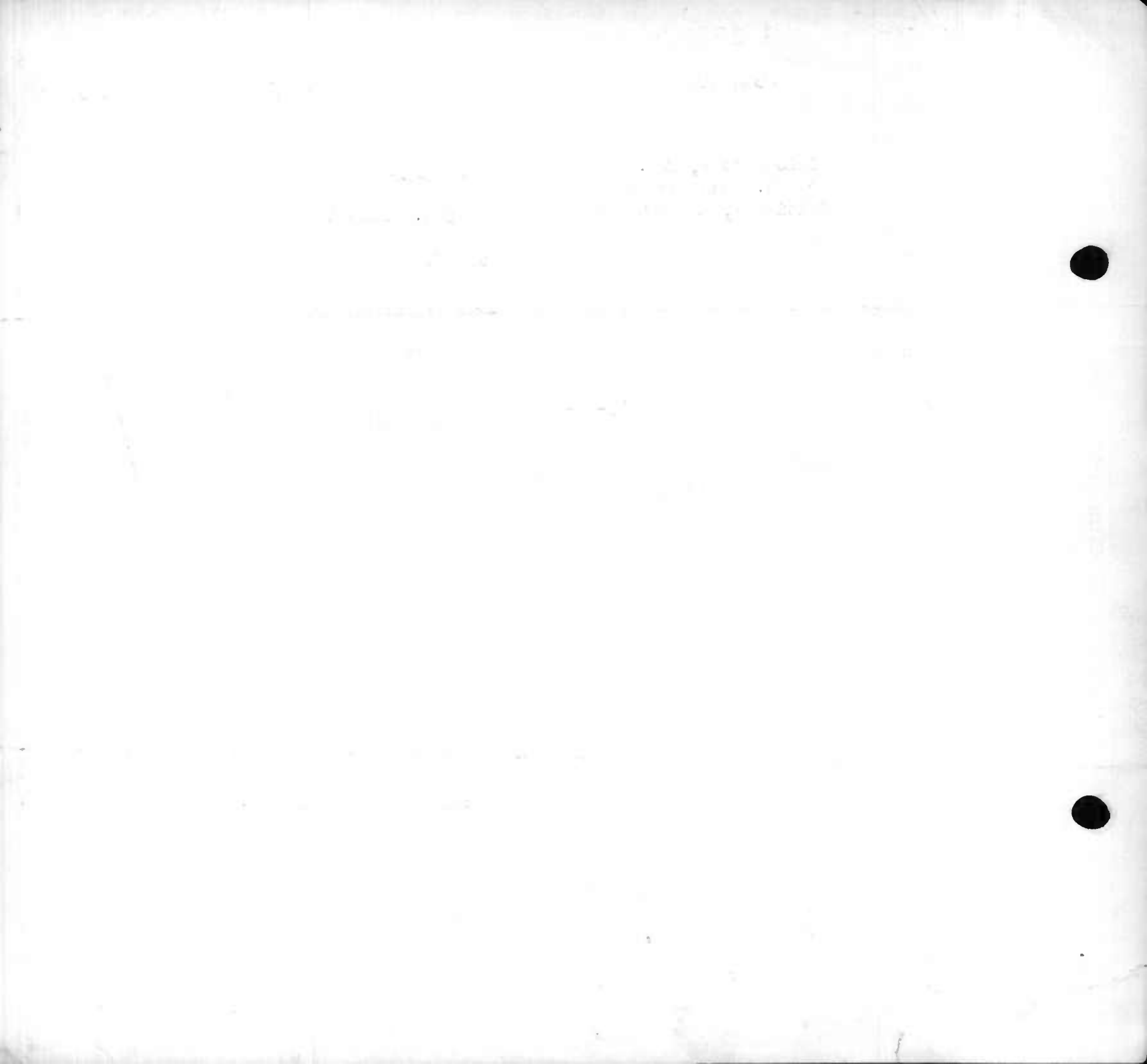
1. NAME OF DECEASED (Type or Print) <b>Cleveland Solomon</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 23 71</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>1223 E. Biddle St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 23 71 1:15 p M.</b>	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>3-15-29</b>		10. AGE (In years lost birthday) <b>42</b> # Under 1 Yr. # Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>250-30-8129</b>	
18. INFORMANT <b>1223 E. Biddle St. ADDRESS</b> <b>Mrs. Margarit Curtis Solomon</b>		19. CAUSE OF DEATH <b>Tuberculosis</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/24/71</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-29-1971</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 28 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>	
25C. FUNERAL DIRECTOR <b>1735 Harford Ave. 21213</b>		25D. ADDRESS <b>Marshall W. Jones, Jr.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 12002</span>	
BIRTH NO. <span style="font-size: 1.5em;">H-435</span>		71 12002		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">John HILTON</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12/20/71</span> <span style="float: right;">7:15 A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">2101</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">90</span> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <span style="font-size: 1.2em;">M</span>			6. RACE <span style="font-size: 1.2em;">W</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Laborer</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Rockville, Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">unk.</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">unk.</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">215-03-1683</span>		17. INFORMANT <span style="font-size: 1.2em;">Henry E. Prentiss</span> ADDRESS <span style="font-size: 1.2em;">8452 Piney Branch Court Silver Springs, Md. 20901</span>	
18. <span style="font-size: 1.5em;">4124 I</span> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.2em;">(A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Cardiac Arrest</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">A.S.C.V. Disease</span>  (B) <span style="font-size: 1.2em;">C.V.A. -</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Rhythm Heart failure</span>  (C) <span style="font-size: 1.2em;">Ismo.</span></span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">Sudden</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">December 3</span> 19 <span style="font-size: 1.2em;">71</span> to <span style="font-size: 1.2em;">December 20</span> 19 <span style="font-size: 1.2em;">71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Dec 18</span> 19 <span style="font-size: 1.2em;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">James S. Blum</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">12/20/71</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">JOSEPH S. BLUM MD</span>				23D. ADDRESS <span style="font-size: 1.2em;">1115 N. CALVERT ST.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">12-30-71</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mt. Calvary Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">A.A. Co., Maryland</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">DEC 28 1971</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Jones, Jr.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">1735 Harford Ave. ADDRESS 3 Marshall W. Jones, Jr.</span>			





4-45271 12003

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12003

1. NAME OF DECEASED (Type or Print) Roosevelt Holmes		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 28 71 11:30A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 28 71 11:30A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2001	
9. DATE OF BIRTH 1, 16, 07		10. AGE (in years lost birthday) 64	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Robert L. Layton 1912 W. Fayette Street Baltimore, Md.		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. IMMEDIATE CAUSE (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE [Signature] Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		21. AUTOPSY? (Yes or No) No	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/71	
24C. NAME OF CEMETERY or CREMATORY National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR [Signature]		ADDRESS 2302 W. North Ave. Baltimore, Md.	

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12004

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12004

BIRTH NO.

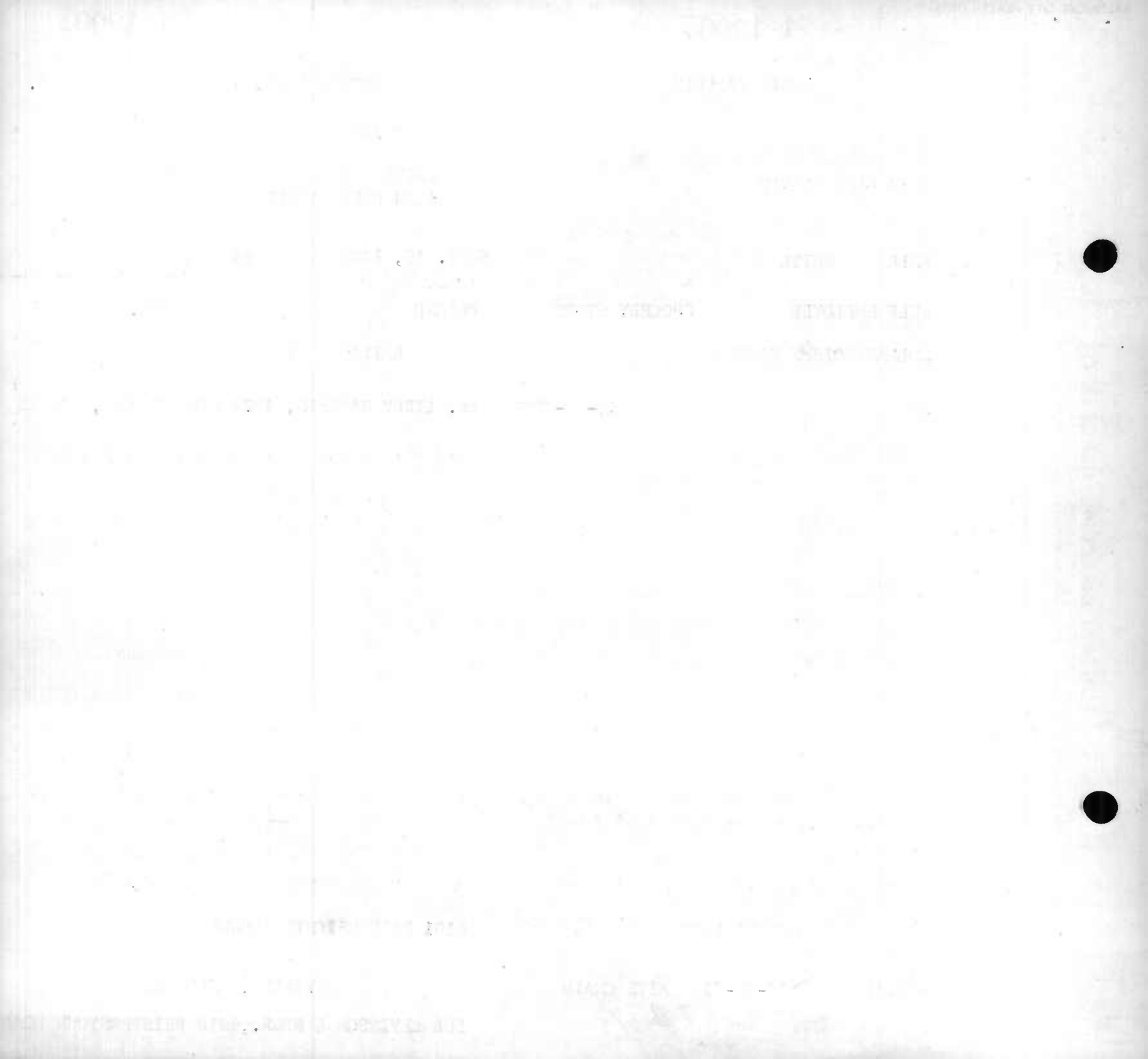
1. NAME OF DECEASED (Type or Print) <b>Andrew Harris</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 27 71 11:30A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Maryland General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year 12 27 71 11:30A. M.	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1702</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>10-14-06</b>		10. AGE (In years lost birthday) <b>65</b>	
11. BIRTHPLACE (State or foreign country) <b>S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>218-05-7892</b>		18. INFORMANT ADDRESS <b>Doried Hudgins 501 McCulloh St.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12-28-71</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Calvary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Coun. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>John E. [unclear]</b>	
25C. FUNERAL DIRECTOR <b>Garvin B. Scruggs</b>		ADDRESS <b>412 E. Preston St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

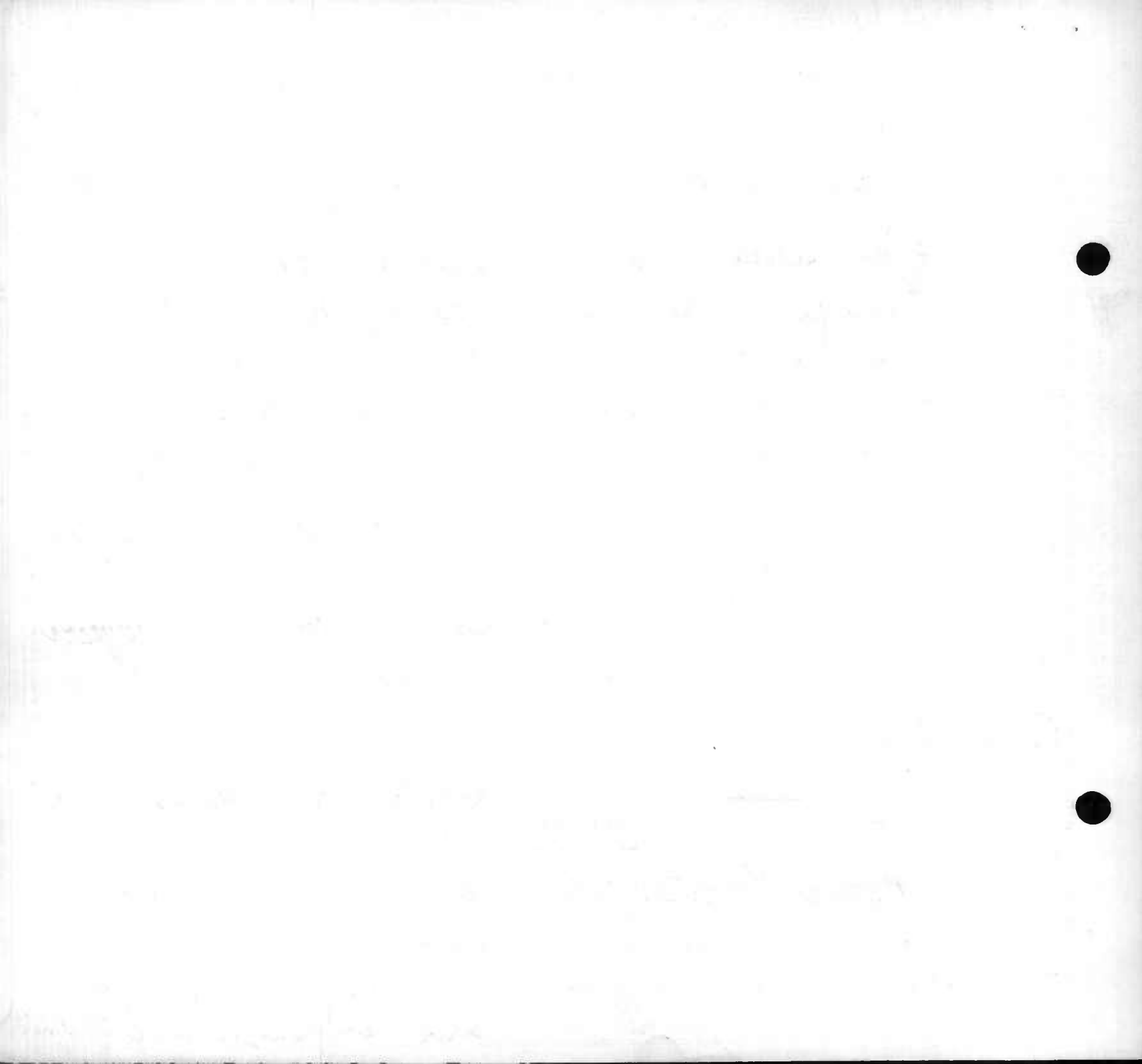
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>71 12005</b>	
S-542 71 12005		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>BORIS SAMUELS</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 27, 1971</b> <b>6</b> <b>A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4024 GLEN AVENUE</b> <b>00</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2720</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>4024 GLEN AVENUE</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 15, 1888</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GROCERY STORE</b>	9. AGE (In years last birthday) <b>83</b>
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ZOLMAN MOISHE SAMUELS</b>		14. MOTHER'S MAIDEN NAME <b>BAILA ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-32-2732</b>	17. INFORMANT ADDRESS <b>MRS. LIBBY SAMUELS, 4024 GLEN AVENUE, #21215</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>412.3 17250.9</b> <b>Arteriosclerosis Heart Disease</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>17 years</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>17 years</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>none</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes Mellitus</b> <b>3 years</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>none</b> (C) DUE TO, OR AS A CONSEQUENCE OF: <b>none</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>none</b>	
20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>none</b>		21D. TIME OF INJURY (APPROX.) <b>none</b>	
21E. INJURY OCCURRED White AI <input type="checkbox"/> Not White AI Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>none</b>	
22. I certify that (I) (the hospital) attended the deceased from <b>Jan 28 1954</b> to <b>Dec 27 1971</b> , that (I) (we) last saw the deceased alive on <b>Dec 27 1971</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Manuel Levin M.D.</b>		23B. DATE SIGNED <b>12/27/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>MANUEL LEVIN</b>		23D. ADDRESS <b>6101 PARK HEIGHTS AVENUE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-27-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>AITZ CHAIM</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>SOL LEVINSON &amp; BROS.</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b>		25D. ADDRESS <b>6010 REISTERSTOWN ROAD</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 12006	
<div style="display: flex; justify-content: space-between;"> <span>W-420 71 12006</span> <span>BIRTH NO.</span> </div>							
1. NAME OF DECEASED (Type or Print) <b>WOLK, SARAH</b>				2. DATE AND HOUR OF DEATH <b>12-26-71 8:00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 Sinai Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>New York</b> B. COUNTY <b>V29</b> C. CITY OR TOWN <b>Brooklyn</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1379 54<sup>th</sup> Street</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/20/1900</b>		9. AGE (in years lost birthday) <b>71</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Wolk</b>				14. MOTHER'S MARRIED NAME <b>Baala Donohy</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>078-20-3560</b>		17. INFORMANT ADDRESS <b>Rabbi Joseph Wolk 5440 Nelson Ave</b>			
18. <b>4123142307</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Ht. Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Smility</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>1 year</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b> <b>1 year</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes Mellitus</b> <b>10 years</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>November 19 71</b> to <b>Dec 26, 19 71</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>Dec 26, 19 71</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>not</del> ) view the body after death.							
23A. SIGNATURE <b>Marvin Goldstein, M.D.</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/26/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR MARVIN GOLDSTEIN</b>				23D. ADDRESS <b>8205 ANITA ROAD</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>12/27/71</b>		24C. NAME of CEMETERY or CREMATORY <b>King Solomon</b>		24D. LOCATION (City, town, or county) (State) <b>Clifton New Jersey</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>Charles E. Fabe, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Solo Levinson &amp; Bros, Inc 6010 Rectorstown Rd</b>			

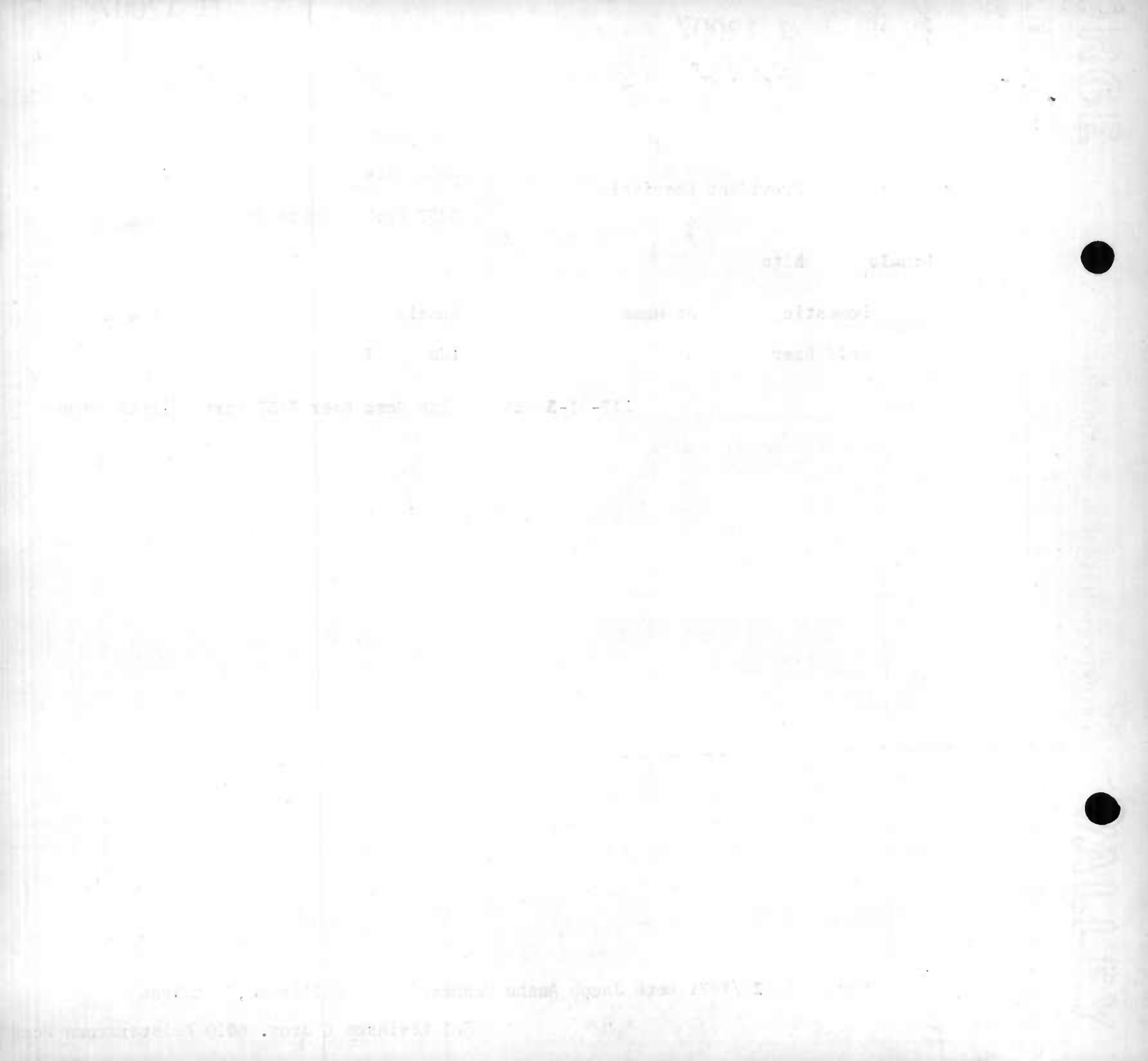




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 12007		REG. NO.	
<div style="display: flex; justify-content: space-between;"> <div> <p>B-600 71 12007</p> <p><b>BIRTH NO.</b></p> </div> <div> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p><b>1. NAME OF DECEASED</b> (Type or Print)</p> <p><b>ANNA BAER</b></p> </div> <div> <p><b>2. DATE AND HOUR OF DEATH</b></p> <p><b>DEC 25, 1971 7 a.m.</b></p> </div> </div>							
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>39 Provident Hospital</b></p>				<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <b>Maryland</b> B. COUNTY <b>1512</b></p> <p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>3437 Park Heights Avenue</b></p>			
<p><b>5. SEX</b></p> <p><b>Female</b></p>		<p><b>6. RACE</b></p> <p><b>White</b></p>		<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b></p> <p><b>75</b></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p> <p><b>Domestic</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p> <p><b>At Home</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country)</p> <p><b>Russia</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b></p> <p><b>U S A</b></p>	
<p><b>13. FATHER'S NAME</b></p> <p><b>Wolf Baer</b></p>				<p><b>14. MOTHER'S MAIDEN NAME</b></p> <p><b>Ida ?</b></p>			
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><b>No</b></p>		<p><b>16. SOCIAL SECURITY NO.</b></p> <p><b>217-01-3001A</b></p>		<p><b>17. INFORMANT ADDRESS</b></p> <p><b>Miss Rose Baer 3437 Park Heights Avenue</b></p>			
<p><b>18. CAUSE OF DEATH</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>							
<p><b>19A. DATE OF OPERATION</b></p> <p><b>0</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No)</p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>			
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p><b>21E. INJURY OCCURRED</b></p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>			
<p><b>22. I certify that (1) (this hospital) attended the deceased from Jan. 19 62 to Dec. 25 19 71, that (1) (we) last saw the deceased alive on Dec. 21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b></p>							
<p><b>23A. SIGNATURE</b></p> <p><i>David I. Miller</i></p>				<p><b>23B. DATE SIGNED</b></p> <p><b>Dec. 26-71</b></p>		<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type)</p> <p><b>David I. Miller</b></p>				<p><b>23D. ADDRESS</b></p> <p><b>Scuair Hospital - Baltimore</b></p>			
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)</p> <p><b>Burial</b></p>		<p><b>24B. DATE</b></p> <p><b>12/26/1971</b></p>		<p><b>24C. NAME OF CEMETERY or CREMATORY</b></p> <p><b>Beth Jacob Anshe Veshear</b></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State)</p> <p><b>Baltimore, Maryland</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b></p> <p><b>DEC 29 1971</b></p>		<p><b>25B. NAME OF REGISTRAR</b></p> <p><b>Robert E. Miller</b></p>		<p><b>25C. FUNERAL DIRECTOR ADDRESS</b></p> <p><b>Sol Levinson &amp; Bros. 6010 Reisterstown Road</b></p>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.	
H-550		71 12008		71 12008			
1. NAME OF DECEASED (Type or Print) <u>Arnold E. Hinman</u>				2. DATE AND HOUR OF DEATH <u>12/25/71</u> <u>12:15</u> <u>A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>NEW YORK CITY N.Y.</u> B. COUNTY <u>V29</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HSPITAL</u> <u>33</u>				C. CITY OR TOWN <u>WARSAW</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>73 WEST COURT STREET</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03/20/104</u>	9. AGE (in years last birthday) <u>67</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCTOR</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>CANADA</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>HINMAN, EDWARD J.</u>				
14. MOTHER'S MAIDEN NAME <u>ISAAC, EDITH</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>				
16. SOCIAL SECURITY NO. <u>445 30 7623</u>			17. INFORMANT <u>Edward Hinman - M.D.</u>				
18. CAUSE OF DEATH <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) <u>Circulatory Collapse</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</u> <u>Pulmonary Embolus</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>Venous Thrombosis</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>Atherosclerotic Heart disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>30 minutes</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u>							
19A. DATE OF OPERATION <u>12/21/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ventricular Aneurysm</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> 19 <u>71</u> to <u>12/25</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/25</u> 19 <u>71</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>William J. Anderson M.D.</u>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>William J. Anderson M.D.</u>	
23D. ADDRESS <u>Johns Hopkins Hosp Baltimore</u>				23E. PHYSICIAN'S DEGREE <u>M.D.</u>		23F. PHYSICIAN'S SPECIALTY <u>Internal Medicine</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>12-27-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>LODGE PARK CREMATORY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1971</u>		25B. NAME OF REGISTRAR <u>Valerie E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>W.B. Cook-Brooks-Townson Inc.</u>		25D. ADDRESS <u>Townson, Md.</u>	



W-600

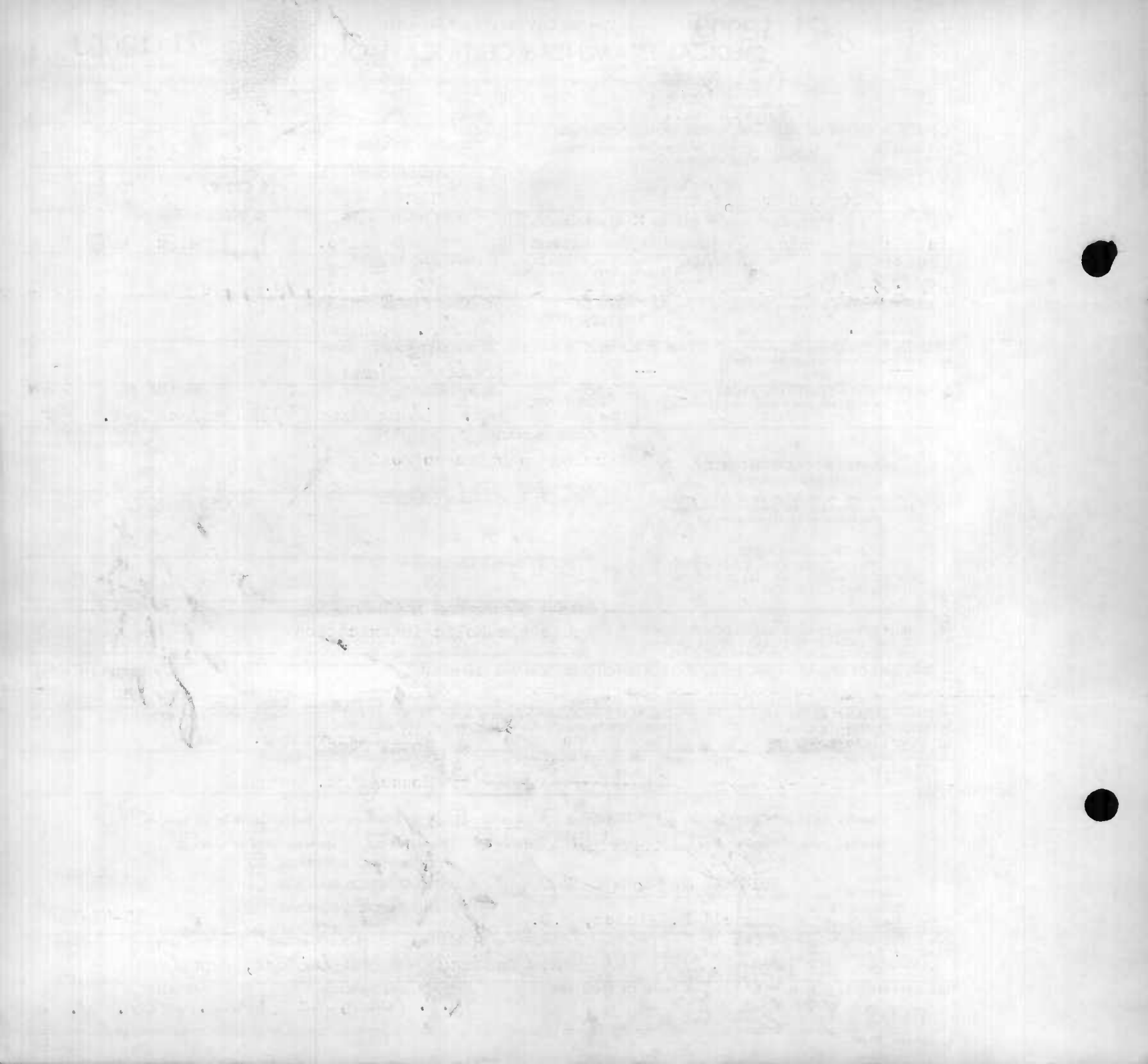
71 12009

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12009  
REG. NO.

1. NAME OF DECEASED (Type or Print) <i>Marie EFFIE WARE</i>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hospital</i>		3. DATE PRONOUNCED DEAD Month Day Year Hour <i>12 26 1971 9:50 a.m.</i>	
6. SEX <i>female</i>		7. RACE <i>white</i>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <i>Balto.</i>	
9. DATE OF BIRTH <i>Sept. 3, 1935</i>		10. AGE (In years lost birthday) <i>36</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto.</i>		12. CITIZEN OF <i>USA</i>	
13. FATHER'S NAME <i>John E. Holbrooks</i>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>---</i>	
15. MOTHER'S MAIDEN NAME <i>Bedd Williams</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no none</i>	
17. SOCIAL SECURITY NO. <i>yes</i>		18. INFORMANT ADDRESS <i>Mr. Wilbur Ware 4921 Eastern Ave.</i>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Carbon monoxide poisoning</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Acute alcoholic intoxication</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <i>yes</i>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>home</i>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <i>4921 Eastern Ave. 2605</i>		22F. HOW DID INJURY OCCUR? <i>House fire.</i>	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <i>12-26-71 a.m.</i>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>Russell S. Fisher, M.D.</i> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>12-27-71</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Dec 28, 1971</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 29 1971</i>		25B. NAME OF REGISTRAR <i>Russell S. Fisher, M.D.</i>	
25C. FUNERAL DIRECTOR <i>J.A. Moran, Inc</i>		25D. ADDRESS <i>3000 E. Balto. St.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-320 71 12010		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12010	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Irvin L. Sheetz		2. DATE AND HOUR OF DEATH 12-26-'71 2 30 a. m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Keswick Home - 700 W 40th St.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1307			
FULL NAME OF HOSPITAL OR INSTITUTION 91		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore, Md.	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 700 W. 40th St.		21211	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-04	9. AGE (in years last birthday) 67	If Under 1 Yr. Months Days 11
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George Sheetz		14. MOTHER'S MAIDEN NAME Adeline King		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) XX XX		16. SOCIAL SECURITY NO. 220-54-2653		17. INFORMANT Keswick Records, 700 W. 40th. St.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF: (B) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs 2 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Congenital mental retardation			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 19 56 to 26 Dec 19 71 that (I) (we) last saw the deceased alive on 26 Dec 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harold P. Biehl M.D.		23B. DATE SIGNED 12/26/71		23C. PHYSICIAN'S NAME (Type) HAROLD P. BIEHL M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/28/71		24C. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR E. G. G. G.		25C. FUNERAL DIRECTOR Albert L. Leaf Bx. 348 Williamsport, Md.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-624 71 12011		CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12011	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HILDA K. MARSHALL		12-26-71 8 45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION GOOD SAMARITAN HOSPITAL 45		A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1001 N. CHARLES ST.			
5. SEX F	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-23-12	9. AGE (In years last birthday) 59	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME DURWARD KEAT HARDING		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-07-4526		17. INFORMANT Hospital	
18. 734.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE UREMIA DUE TO, OR AS A CONSEQUENCE OF: (B) SCLERODERMA OF KIDNEY DUE TO, OR AS A CONSEQUENCE OF: (C) SCLERODERMA (Prog. Systemic Sclerosis)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2 Nov		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 13 Dec 19 71 to 26 Dec 19 71 that (I) (we) last saw the deceased alive on 25 Dec 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harvey M. Golomb M.D.		23B. DATE SIGNED 26 Dec 71		23C. PHYSICIAN'S NAME (Type) HARVEY M. GOLOMB M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/29/71		24C. NAME OF CEMETERY OR CREMATORY Greenmount Cem	
24D. LOCATION Dyers Md		24E. NAME OF REGISTRAR Robert E. Selby, M.D.		24F. FUNERAL DIRECTOR Theodore J. Kervy	
24G. ADDRESS 1600 Hollins St		24H. DATE REC'D BY HEALTH DEPT. DEC 29 1971		24I. NAME OF REGISTRAR Robert E. Selby, M.D.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12012		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12012	
1. NAME OF DECEASED (Type or Print) MORRIS EMMA A				2. DATE AND HOUR OF DEATH Dec. 25 / 71 11 <sup>10</sup> P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION H2SMA1 HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND		B. COUNTY		2719	
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 5500 MERVILLE AVE					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-1-95		9. AGE (In years last birthday) 76		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY <del>212 09 7700</del>		11. BIRTHPLACE (State or foreign country) M-d		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Imhoff				14. MOTHER'S MAIDEN NAME Matilda Cramlitt					
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212 09 7700		17. INFORMANT R. Pinto		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cerebral Respiratory Arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction.					
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Dec 23 1971 to Dec 25 1971 that (I) (we) last saw the deceased alive on Dec 25 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE R. Pinto				23B. DATE SIGNED Dec 25 / 71		23C. PHYSICIAN'S NAME (Type) R. Pinto			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 28 Dec 71		24C. NAME OF CEMETERY or CREMATORY Mays Chapel Cem		24D. LOCATION (City, town, or county) (State) Baltimore Co Md			
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR R. Pinto		25C. FUNERAL DIRECTOR Burgess Funeral Home		ADDRESS Baltimore Md			

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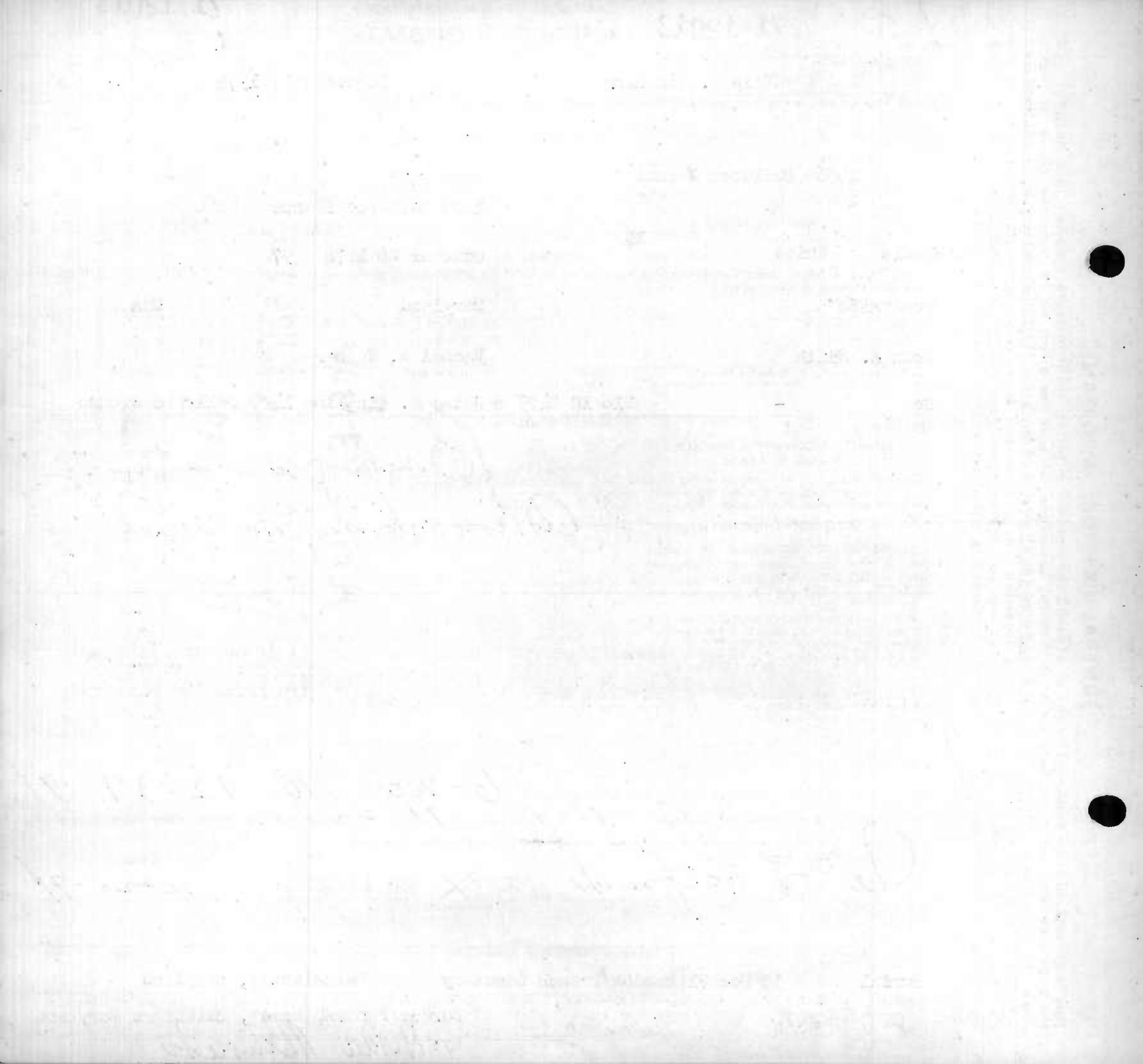
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

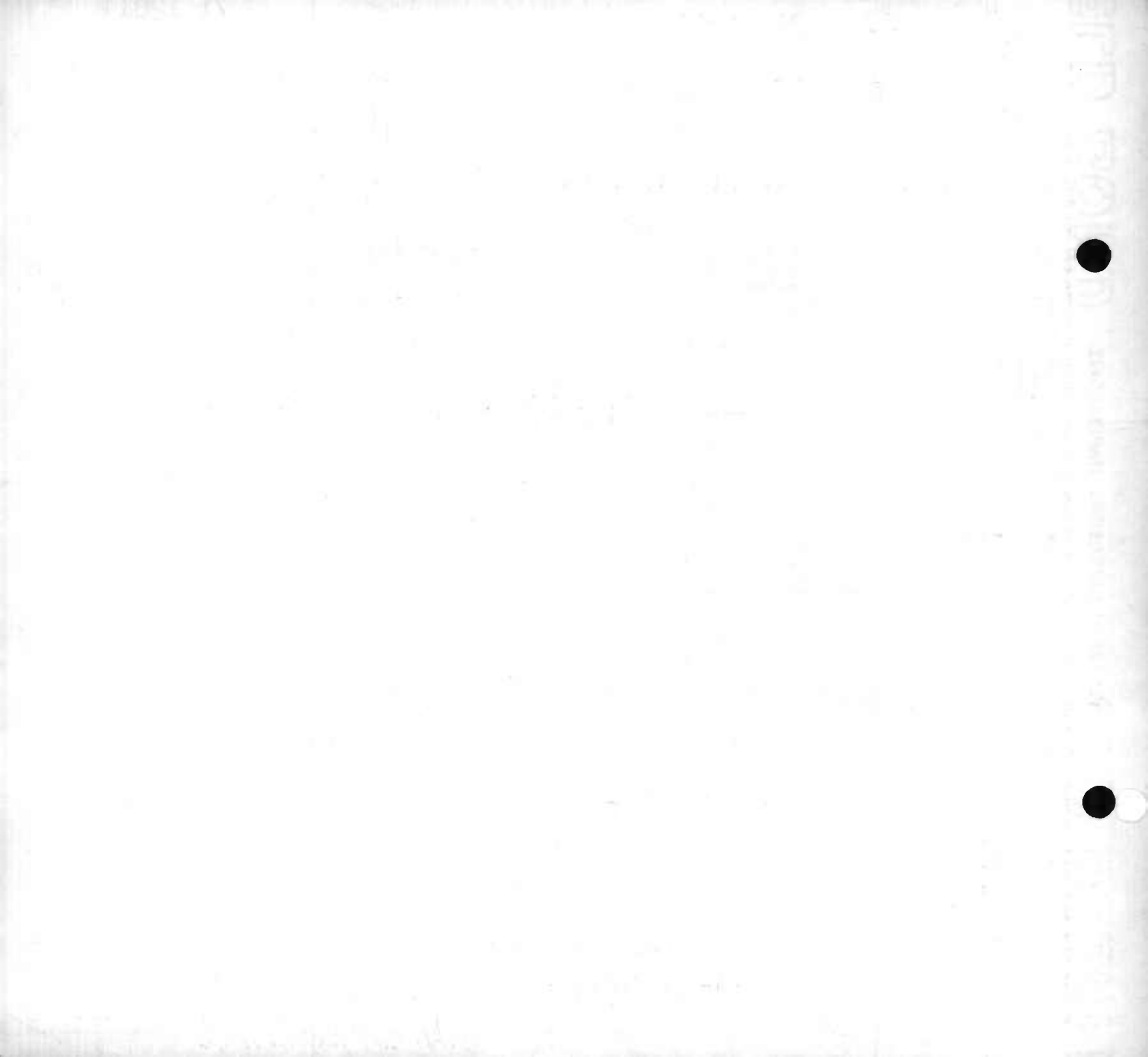
BALTIMORE CITY HEALTH DEPARTMENT				71 12013		71 12013	
Y-524 71 12013				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Effie T. Yingling				December 27 1971		6 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
00 1406 Dellwood Avenue				Maryland		1348	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				1406 Dellwood Avenue			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		October 20 1874 97	
						9. AGE (In years last birthday)	
						If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife						Maryland	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
John A. Smith				USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No -				216 10 2425 B		Jesse E. Yingling 1406 Dellwood Avenue	
18. 44091 CAUSE OF DEATH				ADDRESS			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Broncho-pneumonia, terminal			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Arteriosclerosis, generalized			
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 6-20 1970 to 12-27 1971, that (I) (we) last saw the deceased alive on 11-1 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Wm E Helfrich				12-28-71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		30 Dec 71		Meadow Branch Cemetery		Westminster, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 29 1971		36 E. E. E. E. E.		Burgee Funeral Home		Baltimore Maryland	
By: Wm E Helfrich							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">71 12014</span>	
D-120 71 12014				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>E. Siffrein Davis</u>			2. DATE AND HOUR OF DEATH <u>December 26, 1971</u> <u>10 40</u> <u>A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1307</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4129 Roland Avenue</u> <u>21211</u>		
5. SEX <u>Female</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>05/31/01</u>	9. AGE (In years last birthday) <u>70 yrs</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Alexander Rich</u>			14. MOTHER'S MAIDEN NAME <u>Ellen MacRoberts</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216 14 3326</u>	17. INFORMANT ADDRESS <u>S. Chaplin Davis 4129 Roland Avenue</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of sigmoid</u> <u>colon with extensive subperitoneal and liver metastases.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Oct 71 - Dec 26, 71</u>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>12-22-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CARCINOMA SIGMA</u> <u>- GID COLON LAPAROTOMY</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-20-1971</u> to <u>26-12-1971</u> that (I) (we) last saw the deceased alive on <u>26-DEC-25-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. J. Kharaka MD</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>DEGREE</u>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>27 Dec 71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount Crematory</u>	
24D. LOCATION <u>Baltimore Maryland</u>		24E. NAME OF REGISTRAR <u>DEGREE</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1971</u>		25B. NAME OF REGISTRAR <u>DEGREE</u>		25C. FUNERAL DIRECTOR <u>Burges Funeral Home Baltimore Maryland</u>	
25D. ADDRESS <u>By: Harold Kharaka Jr</u>					

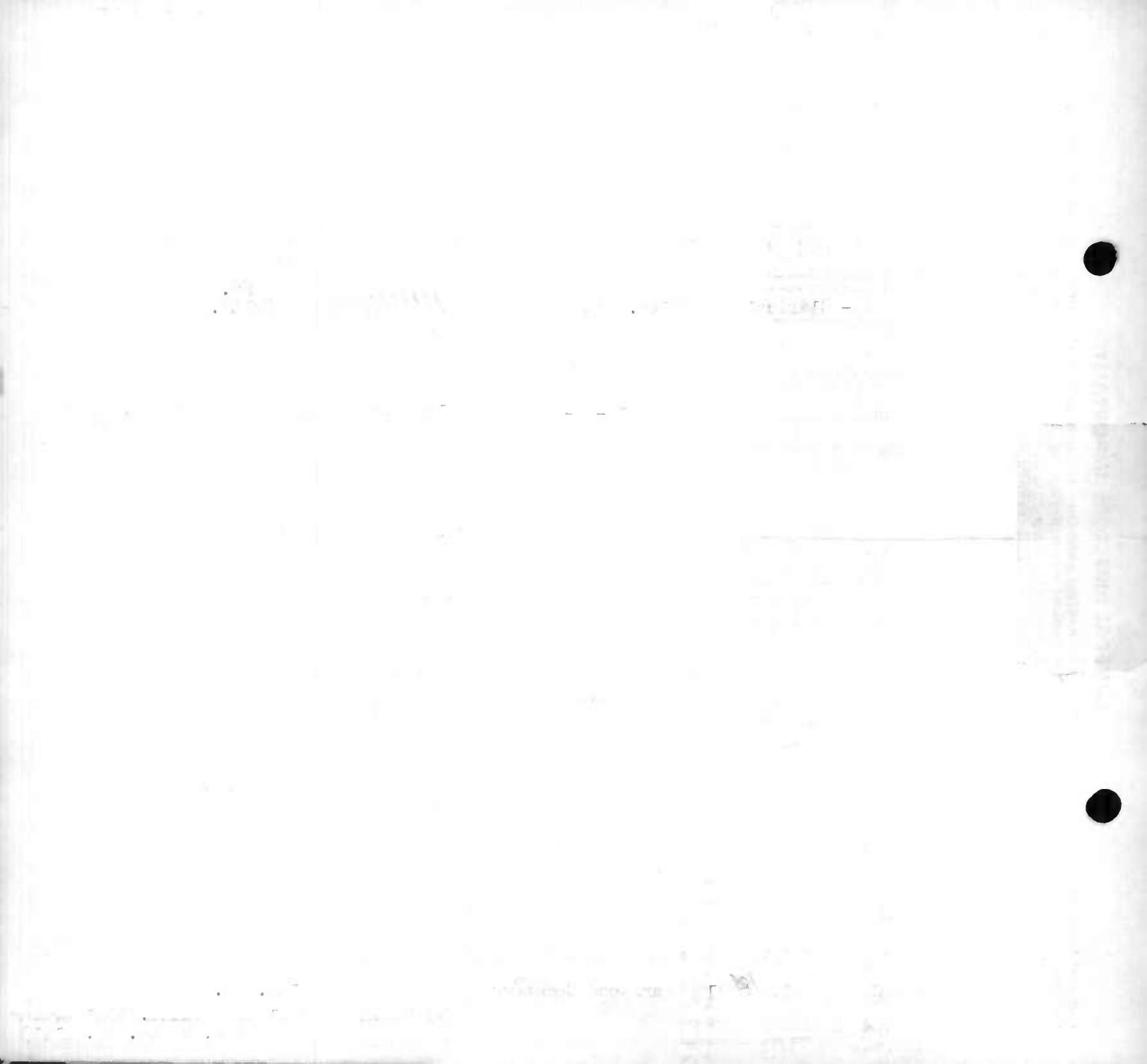




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-200 71 12015		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12015	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
LOOS, GEORGE A.		23/12/71 10.30 hrs. A. M.			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN		6. INSIDE CITY LIMITS?	
MD		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. STREET AND NUMBER		8. DATE OF BIRTH			
3415 Juneway, MD 21213		8/23/89			
9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?		11. BIRTHPLACE (State or foreign country)	
82		American		Md. Balto.	
12. SEX		13. RACE		14. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY		17. FATHER'S NAME	
Retired - Clerical		Balto. City		Louis Loos	
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		19. SOCIAL SECURITY NO.		20. INFORMANT	
unknown no		271-10-5065		Ella Loos (wife)	
21. ADDRESS		22. same as above			
18. 412.4 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Bronchopneumonia			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Congestive Heart Failure			
		(C) ASCVD, Abdominal Aneurysm			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
23. DATE OF OPERATION		24. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. AUTOPSY? (Yes or No)	
None		none		No	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		27. PLACE OF INJURY (e.g., in or about home, home, factory, street, office bldg., etc.)		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO		None		none	
29. TIME OF INJURY (Approx.)		30. INJURY OCCURRED		31. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		no injury	
32. I certify that (I) (this hospital) attended the deceased from 12/21/1971 to 12/23/1971					
that (I) (we) last saw the deceased alive on 12/23/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
33. SIGNATURE				34. DATE SIGNED	
S. Desai M.D.				12/23/71	
35. PHYSICIAN'S NAME (Type)				36. ADDRESS	
S. J. DESAI M.D.				union Memorial Hospital 21218	
37. BURIAL CREMATION, REMOVAL (Specify)		38. DATE		39. NAME of CEMETERY or CREMATORY	
BURIAL		12/27/71		Parkwood Cemetery	
40. DATE REC'D BY HEALTH DEPT.		41. NAME OF REGISTRAR		42. FUNERAL DIRECTOR'S ADDRESS	
DEC 29 1971		J. J. [unclear]		Schimmek Funeral Homes, Inc. 3531 Brehms Lane, Balto. Md. 21213	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-326 71 12016		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12016	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOSEPH BUTCHYARD</b>		2. DATE AND HOUR OF DEATH <b>12/21/71 445 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>		C. CITY OR TOWN <b>BACTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b> <b>38</b>		E. STREET AND NUMBER <b>809 Hollins St.</b> <b>1803</b>		F. DATE OF BIRTH <b>10/17/07</b>	
5. SEX <b>M</b> 6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <b>64</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>A. BUTCHYARD</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH ROCK</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT ADDRESS	
18. <b>410.7 I</b> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIOGENIC SHOCK</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial INFARCTION</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>—</b>	
(C) DUE TO, OR AS A CONSEQUENCE OF: <b>—</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>—</b>		19A. DATE OF OPERATION <b>—</b>	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>—</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>—</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12/16</b> 19 <b>71</b> to <b>12/21</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12/21</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Walt Whitman Jr MD</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/21/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>WALT WHITMAN</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec. 24, 1971</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Hill Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Fredericksburg Virginia</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher MD</b>		25C. FUNERAL DIRECTOR <b>Fredericksburg, Virginia</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>C-452 71 12017</b></p> <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>71 12017</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <i>ELEANOR M. COLLINS</i></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <i>Dec. 23, 1971 9:50 P.M.</i></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>602</i></p>	
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <i>90 Gould Conv. Home</i></p>		<p><b>C. CITY OR TOWN</b> <i>BA H.O.</i></p>	
		<p><b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
		<p><b>E. STREET AND NUMBER</b> <i>412 N. GLOVER ST.</i></p>	
<p><b>5. SEX</b> <i>F</i></p>	<p><b>6. RACE</b> <i>W</i></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <i>5-17-94</i></p>
		<p><b>9. AGE</b> (In years last birthday) <i>77</i></p>	<p><b>If Under 1 Yr. Months: Days</b> <b>If Under 24 Hrs. Hours: Min.</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>	
<p><b>11. BIRTHPLACE</b> (State or foreign country) <i>MD.</i></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b></p>	
<p><b>13. FATHER'S NAME</b> <i>FREDRICK PRETZSCH</i></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <i>LAURA WINTERLING</i></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i></p>		<p><b>16. SOCIAL SECURITY NO.</b></p>	<p><b>17. INFORMANT</b> <i>MARY COLLINS 412 N. GLOVER ST.</i></p>
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Antisclerotic Heart Disease</i> (B) <i>Chronic Antisclerotic</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____</p>	
<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <i>years</i></p>			
<p><b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Chronic Brain Syndrome, Cerebral.</i></p>			
<p><b>19A. DATE OF OPERATION</b> <i>0</i></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>20A. AUTOPSY?</b> (Yes or No)</p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indify medical examined) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>			
<p><b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p><b>21F. HOW DID INJURY OCCUR?</b></p>			
<p><b>22. I certify that (I) (this hospital) attended the deceased from <i>12/19/71</i> to <i>12/25/71</i> that (I) (we) last saw the deceased alive on <i>12/24/71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <i>Albert B. Bradley</i></p>		<p><b>23B. DATE SIGNED</b> <i>12/27/71</i></p>	
<p><b>23C. PHYSICIAN'S NAME (Type)</b> <i>Albert B. Bradley, M.D.</i></p>		<p><b>23D. ADDRESS</b> <i>4900 Belair Road 21206</i></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <i>BURIAL</i></p>		<p><b>24B. DATE</b> <i>12-28-71</i></p>	
<p><b>24C. NAME OF CEMETERY or CREMATORY</b> <i>HOLY REDEEMER CEM.</i></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <i>BALTIMORE MD.</i></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>DEC 29 1971</i></p>		<p><b>25B. NAME OF REGISTRAR</b> <i>E. S. S. M.D.</i></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <i>B. Dabrowski</i></p>		<p><b>ADDRESS</b> <i>250 E. BA H.O. ST.</i></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>71 12018</b>	
G-620 71 12018		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GORSKI, MRS. MARY</b>	
2. DATE AND HOUR OF DEATH <b>12-26-71 11 AM</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>US.A.</b>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>5 CHURCH Home and Hospital 100 N Broadway</b>	
C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>100 N Broadway</b>		5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>3-14-02</b>		9. AGE (In years last birthday) <b>69</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>CHICAGO</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN MROZ</b>		14. MOTHER'S MAIDEN NAME <b>ANNA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-32-2454</b>	
17. INFORMANT <b>M. GORSKI</b>		ADDRESS <b>110 PORT ST.</b>	
18. CAUSE OF DEATH <b>250.9 I</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>possible MI and CHF</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes, CHF</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>2</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-25-71</b> 19 to <b>12-26-71</b> that (I) (we) last saw the deceased alive on <b>12-26-71</b> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>A. Sajadi</b>		23B. DATE SIGNED <b>12-26-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>R. SAJADI</b>		23D. ADDRESS <b>CHURCH Home and Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-30-71</b>	
24C. NAME of CEMETERY or CREMATORY <b>Holy ROSARY Cemetery</b>		24D. LOCATION <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>Rose E. ...</b>	
25C. FUNERAL DIRECTOR <b>B. Dabrowski</b>		ADDRESS <b>2414 E. Balto. St.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-630 71 12019		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12019	
1. NAME OF DECEASED (Type or Print) <b>Wanda Gordy</b>				2. DATE AND HOUR OF DEATH <b>12-22-71 6:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>North Charles Gen. Hosp.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>Md.</b>		B. COUNTY <b>2636</b>	
C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>1400 Angelsea St.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-6-28</b>	9. AGE (In years last birthday) <b>43</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Austin Gunn</b>				14. MOTHER'S MAIDEN NAME <b>Mattie Goodman</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or Unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>487-40-183</b>		17. INFORMANT <b>15. Gordy 1400 Angelsea St.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>15-7-91</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Ca of the Pancreas</b>				CAUSE OF DEATH <b>Cardiac Arrest</b> <b>Pulmonary Embolism</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Ca of the Pancreas</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>12-14-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Obstructive jaundice</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-6</b> 19 <b>71</b> to <b>12-22</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12-22</b> 19 <b>71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Narciso E. Ignacio</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-22-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Narciso E. Ignacio</b>		23D. ADDRESS <b>North Charles Gen. Hosp.</b>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>12-23-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>214 E. Baltimore St.</b>		ADDRESS	

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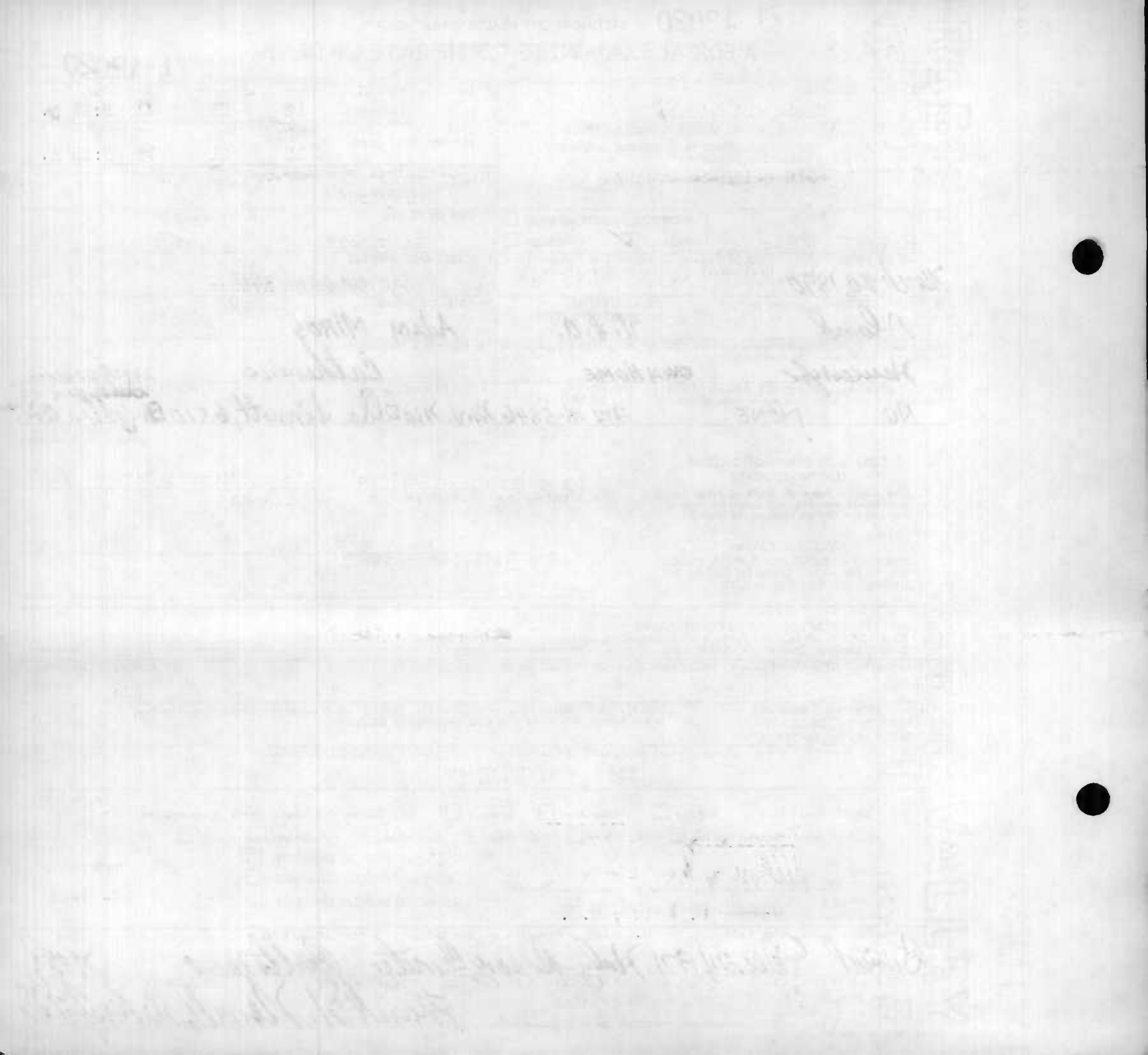
12. 2000 2000 2000

G-412

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12020

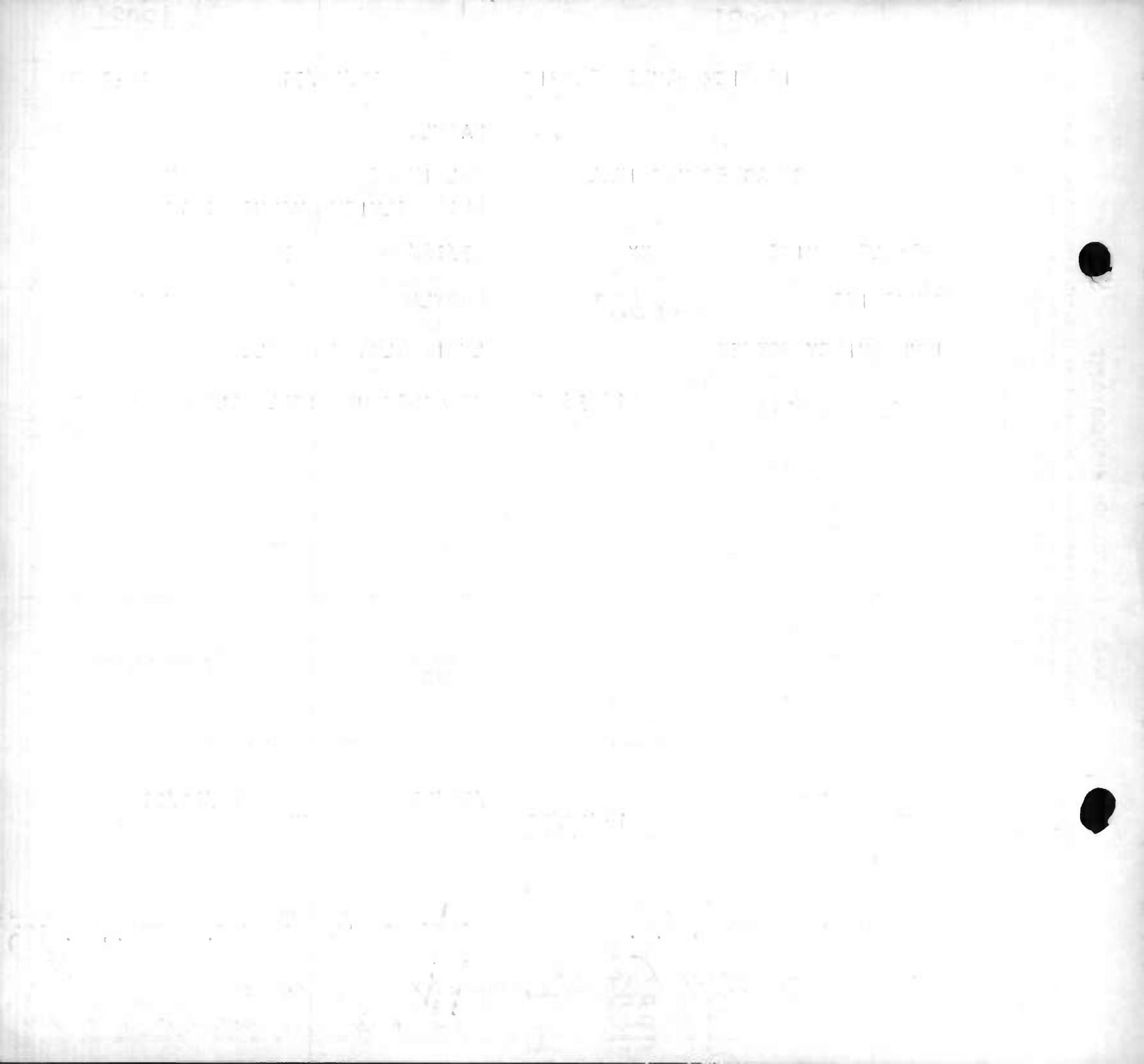
1. NAME OF DECEASED (Type or Print) <b>Viola Golebieski</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 21 71 3:25 A. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>6510 Brighton Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 21 71 3:25 A. M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2831</b>			
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>March 20, 1890</b>		10. AGE (in years lost birthday) <b>81</b>	D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	E. STREET AND NUMBER <b>6510 Brighton Avenue</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	13. FATHER'S NAME <b>ADAM MIROS</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>212-18-5846</b>	15. MOTHER'S MAIDEN NAME <b>Catherine</b>
18. INFORMANT <b>Mrs. Matilda Linnett</b>		ADDRESS <b>Baltimore - 15</b>	
19. CAUSE OF DEATH <b>412.41 + 250.9</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) <b>Diabetes mellitus</b>	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID IT IN BALTIMORE CITY, GIVE EXACT LOCATION	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec. 24, 1971</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert C. ...</b>	
25C. FUNERAL DIRECTOR <b>Frank H. Newell, Pikeville</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-362 71 12021				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12021	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
DIETRICH MAUDE BEATRICE				12/19/71		12:30PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
40 ST AGNES HOSPITAL				MARYLAND		2841	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				4414 BELVIEU AVENUE 21215			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	If Under 1 Yr. Months Days	
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	07/16/84		87		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE			OWN HOME		MARYLAND		U S A
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN QUINCY POTTER				LYDIA ALMA CROSWELL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		NONE		216 36 5424		ST AGNES HOSPITAL BALTO MD 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Pneumonia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				ASCVD and Congestive heart failure			
II				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) failure			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from 12/16/71 to 12/19/71 that (X) (we) last saw the deceased alive on 12/19/71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
TARIQ MAHMOOD, M.D.				12.19.71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. MED. DIRECTOR		23F. STAFF PHYS.	
		CATON & WILKENS AVES. BALTO., MD. 21229					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION	
Burial		Dec. 22/1971		OXFORD CEMETERY		Oxford	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
DEC 29 1971		J. J. J. J.		J. J. J. J.		J. J. J. J.	



A-526 71 12022

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12022  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CALVIN AINSWORTH</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 19 1971 2:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location) <b>4640 Schenley Rd.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 19 1971 2:50 P.M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 28 Feb. 1924		10. AGE (In years lost birthday) 47	
11. BIRTHPLACE (State or foreign country) Chicago, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Ainsworth		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2714	
15. MOTHER'S MAIDEN NAME Catherine McConnell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WW 2	
17. SOCIAL SECURITY NO. 371 22 9012		18. INFORMANT Leonard Ainsworth	
19. CAUSE OF DEATH Subdural hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 4640 Schenley Rd.	
22D. TIME OF INJURY (APPROX.) 12-18-71 P.M. 12:30 m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Fell while intoxicated		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-20-71	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12/23/71	
24C. NAME OF CEMETERY or CREMATORY Gettysburg National		24D. LOCATION (City, town, or county) (State) Gettysburg Penna.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert S. Fisher, M.D.	
25C. FUNERAL DIRECTOR Higinbotham Slack		ADDRESS Ellicott City, Md.	

1-3-72 - Letter from Office of the Chief Medical Examiner, Russell S. Fisher, M.D.

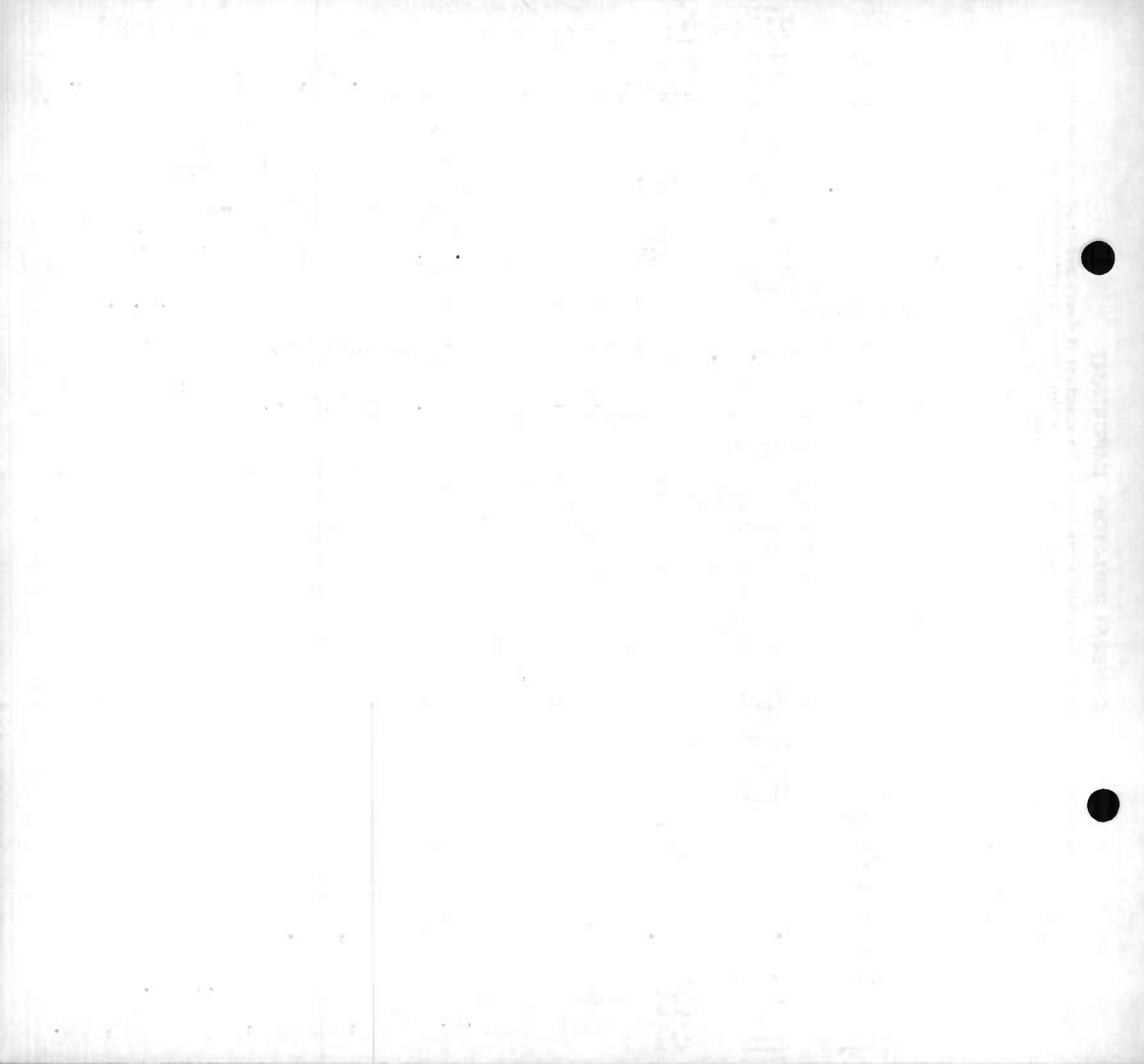
HS



# FUNERAL DIRECTOR: IMPORTANT

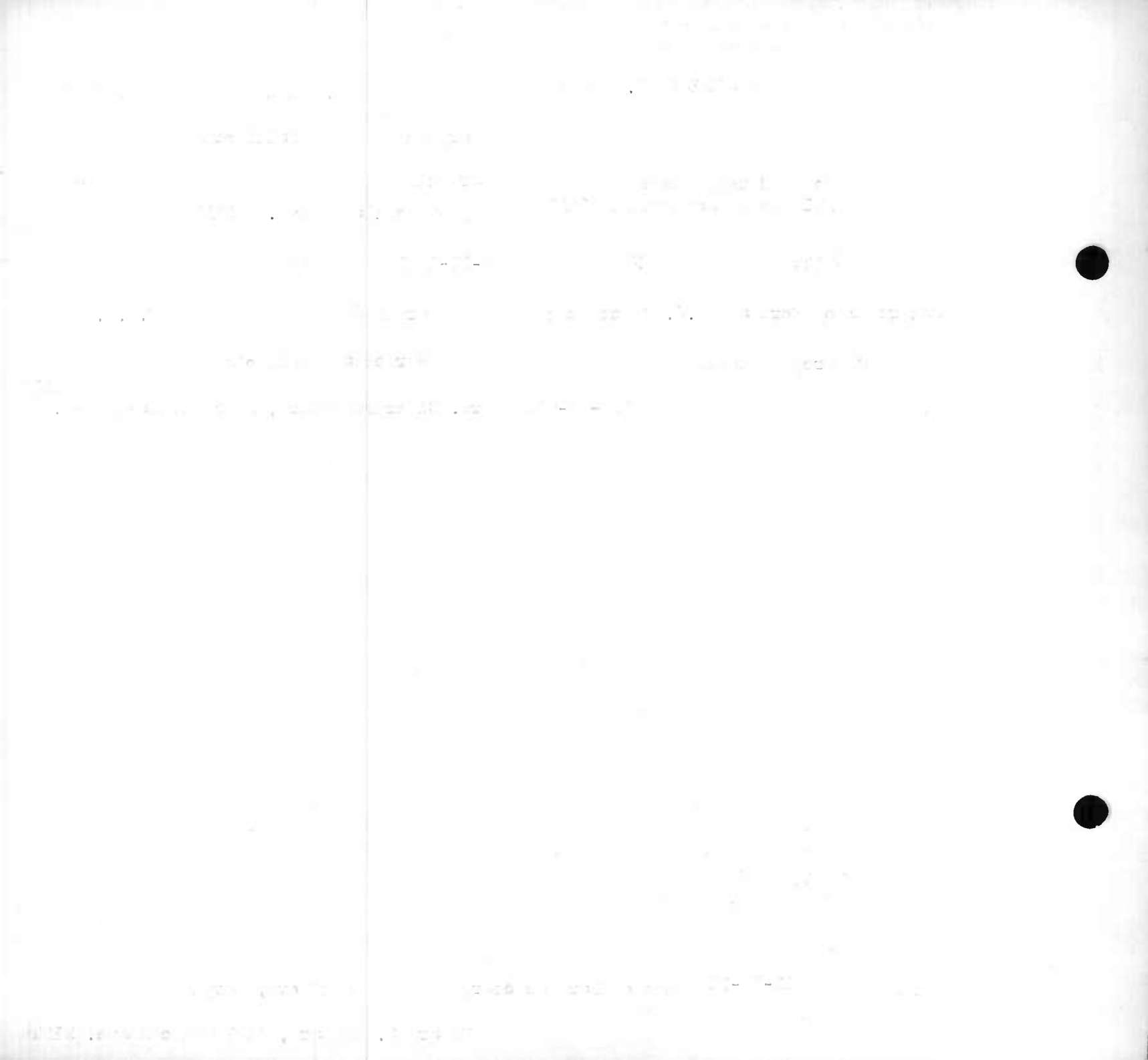
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-452 71 12023		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 71 12023	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		NORMAN MULLINIX		Dec. 24, 1971 11:12 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital		Maryland Howard 6300			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Ellicott City		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 9106 Dunloggin Road			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1890	9. AGE (In years last birthday) 81	10. Under 1 Yr. Months: Days: 4 5 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant-retired		10B. KIND OF BUSINESS OR INDUSTRY General Store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Addison A. E. Mullinix		14. MOTHER'S MAIDEN NAME Laura Mullinix	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-3747A		17. INFORMANT Mrs. Virginia M. Dietrich Same As #4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.01 * 250.9 CORONARY THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis (B) ASHD - Diabetes. HBP (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1968 70 24 Dec 71	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1968 19 to 24 Dec 1971 that (I) (we) last saw the deceased alive on 24 Dec 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Howard E. Hall		23B. DATE SIGNED 24 Dec 71	
23C. PHYSICIAN'S NAME (Type) Dr. Howard E. Hall		23D. ADDRESS Sykesville, Md. 21784			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/27/1971		24C. NAME of CEMETERY or CREMATORY McKendree	
24D. LOCATION (City, town, or county) (State) Howard Co., Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Hall	
25C. FUNERAL DIRECTOR C. M. Walters		25D. ADDRESS Box 326, Sykesville, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

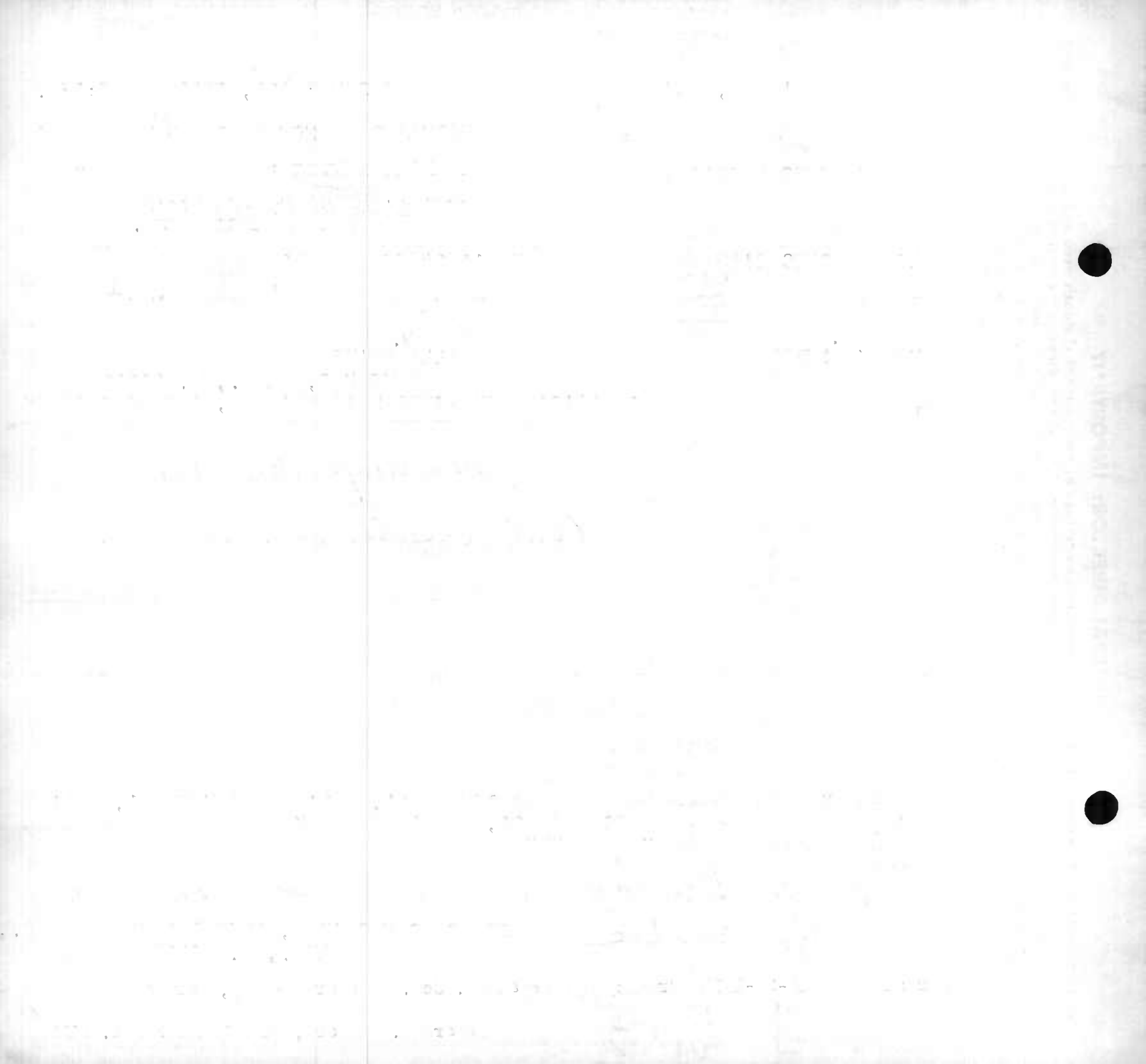
<p><b>N-200</b>      <b>71 12024</b></p>		<p>BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>71 12024</b></p>	
<p><b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>FREDERICK W. NOWECK</b></p>			<p><b>2. DATE AND HOUR OF DEATH</b> <b>DEC 25 1971 4:45 A.M.</b></p>		
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Hood Nursing Home 5313 Edmondson Avenue 21229</b></p>			<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> <b>5300</b> C. CITY OR TOWN <b>Arbutus</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>5003 Westland Blvd. 21227</b></p>		
<p><b>5. SEX</b> <b>MALE</b></p>	<p><b>6. RACE</b> <b>White</b></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>3-24-1887</b></p>	<p><b>9. AGE</b> (In years lost birthday) <b>84</b></p>	<p><b>10. Under 1 Yr.</b> Months: Days: Hours: Min. <b>11. Under 24 Hrs.</b> Min.</p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Shop Foreman</b></p>			<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Government</b></p>		
<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b></p>			<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b></p>		
<p><b>13. FATHER'S NAME</b> <b>Godfrey Noweck</b></p>			<p><b>14. MOTHER'S MAIDEN NAME</b> <b>Henrietta Malinofski</b></p>		
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>			<p><b>16. SOCIAL SECURITY NO.</b> <b>220-44-9415</b></p>		
<p><b>17. INFORMANT</b> <b>Mrs. Elmer Peddicord, 5003 Westland Blvd.</b></p>			<p><b>ADDRESS</b> <b>21227</b></p>		
<p><b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Anterovascular Card.</b> <b>Vasc. Disease -</b> <b>Antecedent Causes</b> <b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b> <b>Cerebral arteriosclerosis</b> <b>Parkinsonism</b></p>			<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>		
<p><b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>					
<p><b>19A. DATE OF OPERATION</b> <b>12-24-71</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY</b> (Yes or No) <b>No</b></p>	
<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>		<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>			
<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>			
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from Nov. 19 64 to Dec 25 19 71 that (I) (we) last saw the deceased alive on Dec 24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>					
<p><b>23A. SIGNATURE</b> <b>HARRY L. KNIPP, MD</b></p>			<p><b>23B. DATE SIGNED</b> <b>12-26-71</b></p>		
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>HARRY L. KNIPP, MD</b></p>			<p><b>23D. ADDRESS</b> <b>4116 EDMONDSON AV. Balt. Md. 21229</b></p>		
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b></p>		<p><b>24B. DATE</b> <b>12-28-71</b></p>		<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Loudon Park Cemetery</b></p>	
<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b></p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 29 1971</b></p>			
<p><b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor, M.D.</b></p>		<p><b>25C. FUNERAL DIRECTOR</b> <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b></p>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 12025	
B-536 71 12025		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
BINDER, ROY D		DECEMBER 21, 1971 5:15P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL 40		A. STATE MARYLAND B. COUNTY HOWARD COUNTY 6300			
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 556 XXXXX AVENUE 7065 WASHINGTON BLVD.					
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/24/00	9. AGE (in years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME D. HENRY BINDER		14. MOTHER'S MAIDEN NAME ELLA WHITE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220241339		17. INFORMANT AVENUES, BALTO., MD. 21229 ST AGNES HOSP RECORDS, WILKENS & CATON	
18. 43141		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.]		(A) IMMEDIATE CAUSE Hemorrhage in Brain stem DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) _____			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 21, 1971 to DECEMBER 21, 1971 that (X) (we) last saw the deceased alive on DECEMBER 21, 1971 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. S. Lee M.D.		23B. DATE SIGNED Dec. 21, 1971		23C. PHYSICIAN'S NAME (Type) Young Soon Lee	
24A. SURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-24-1971		24C. NAME OF CEMETERY or CREMATORY Trinity Episcopal Ch. Cem.	
24D. LOCATION Howard County, Maryland		24E. ADDRESS ST AGNES HOSPITAL, WILKENS & CATON AVES., BALTO., MD. 21229			
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



1. NAME OF DECEASED (Type or Print)		B. George Wilson		2. DATE OF DEATH		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		12 21 71 M.									
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD				Month Day Year Hour				12 21 71 7:07 p. M.			
40 St. Agnes Hospital								5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				A. STATE B. COUNTY				Maryland Howard			
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Elkridge	
9. DATE OF BIRTH		10. AGE (In years lost birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
9-16-1896		75		New York		U.S.A.		John Wilson		Retired		Mary McDonald		Yes		W W I		Mrs. Ethel S. Wilson, 6211 Old Washington Rd.	
19. 4501-812.0		CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Pulmonary embolism		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. UTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
12 16 71 5:15p.		Fracture of left hip				Southwest Blvd- South of Tomday		Subject in car/truck collision- ran into rear of truck											
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS		25D. DATE SIGNED		25E. DATE SIGNED	
Burial		12-24-1971		Good Shepherd Cemetery		Howard County, Maryland		DEC 29 1971		Peter Lipkovic, M.D.		Howard H. Hubbard, 4107 Wilkens Ave. 21229		12/22/71					

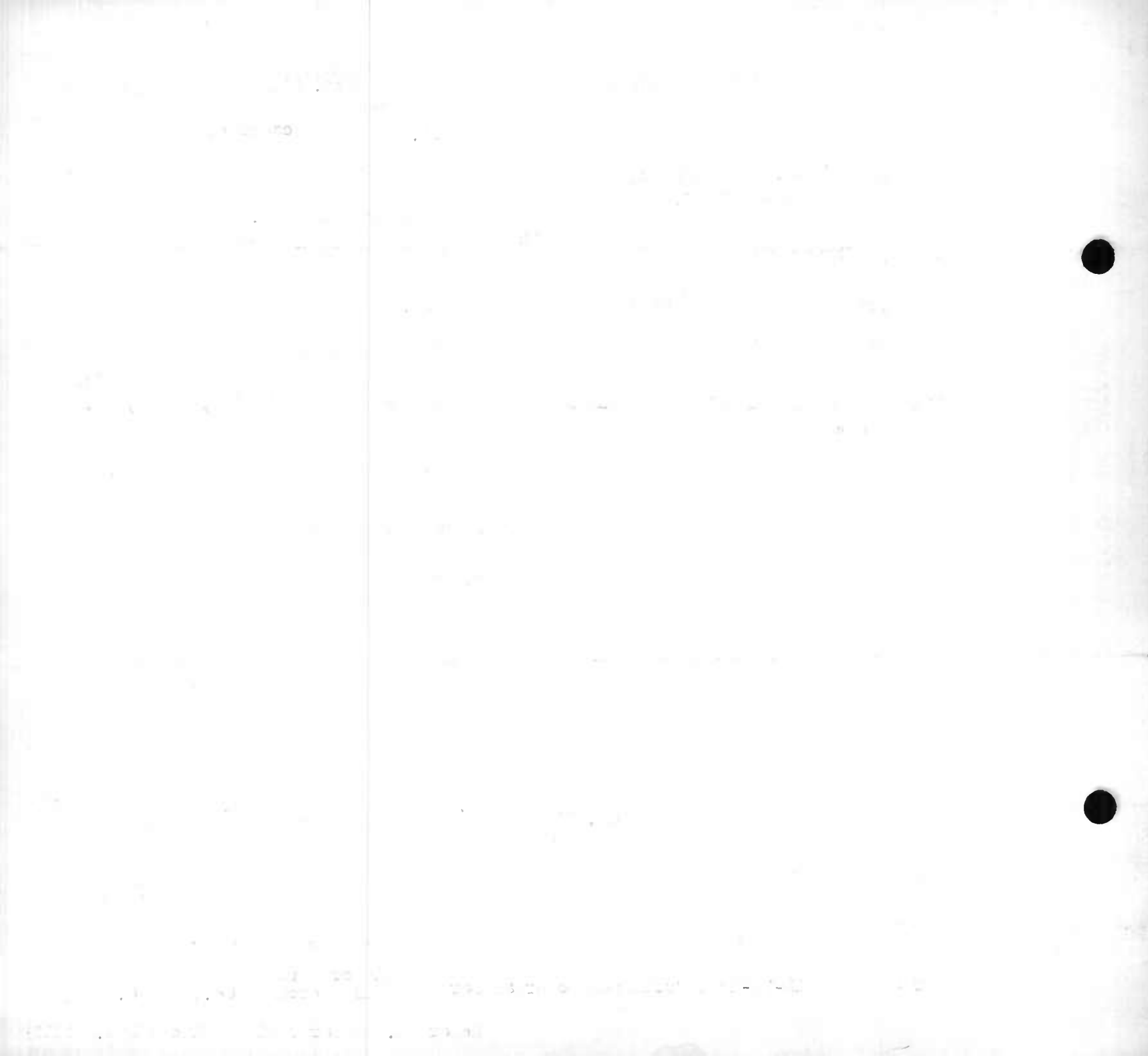




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

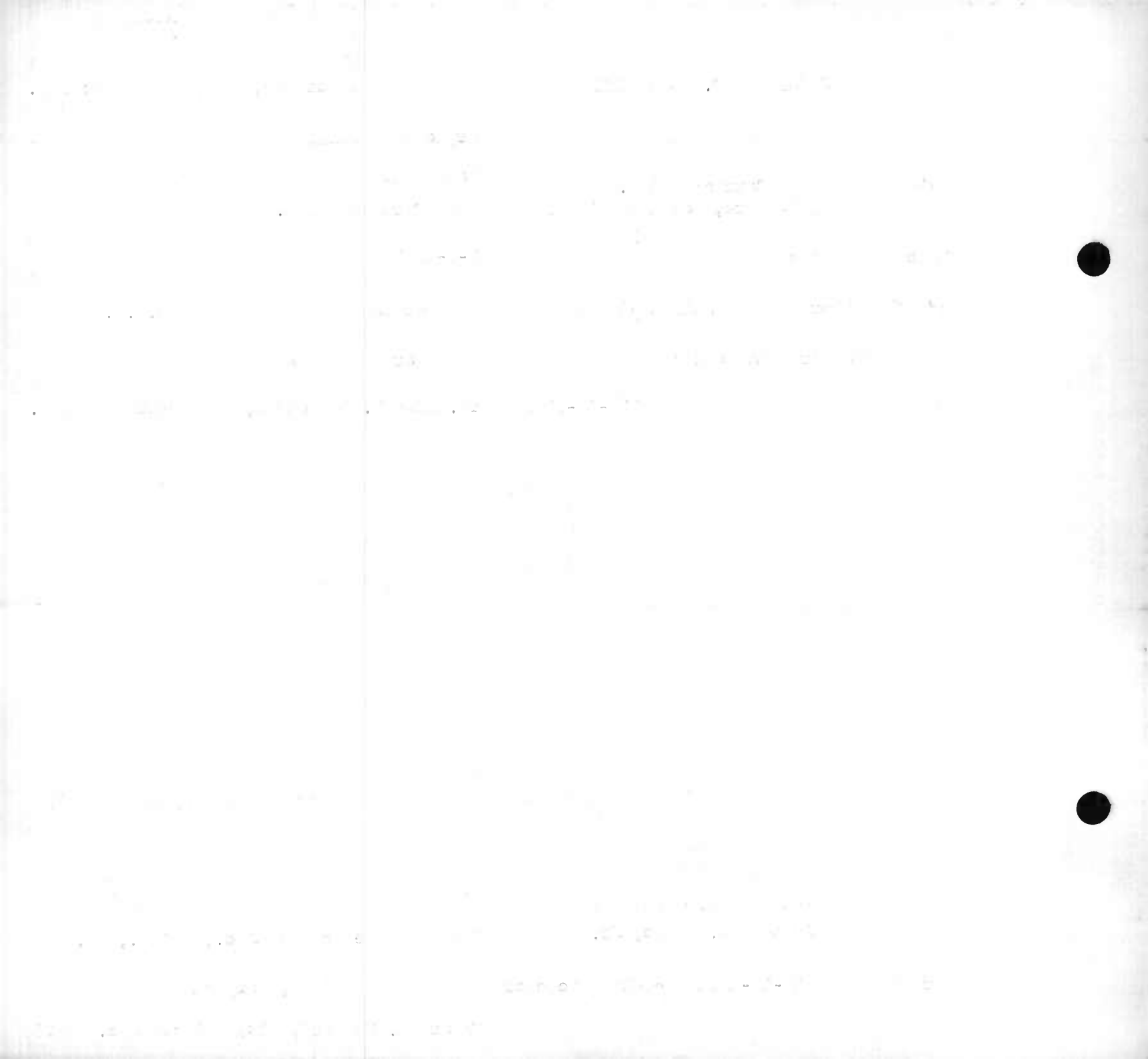
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 12027</span>	
<b>G-642</b> <b>BIRTH NO.</b> <b>71 12027</b>		<b>CERTIFICATE OF DEATH</b>			
<b>1. NAME OF DECEASED</b> (Type or Print) Richard Groholski			<b>2. DATE AND HOUR OF DEATH</b> Dec. 22, 1971      3:05 A. M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE Pa.      B. COUNTY Westernmoreland		
<b>5. SEX</b> M			<b>6. RACE</b> Caucasian		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Unemployed			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> USCG Retired		<b>8. DATE OF BIRTH</b> 9/5/51
<b>13. FATHER'S NAME</b> Frank Groholski			<b>14. MOTHER'S MAIDEN NAME</b> Betty Gartley		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) Yes      CG 1970-1971			<b>16. SOCIAL SECURITY NO.</b> 174-42-1666		<b>9. AGE</b> (In years last birthday) 20
<b>11. BIRTHPLACE</b> (State or foreign country) Pa.			<b>12. CITIZEN OF WHAT COUNTRY</b> USA		
<b>17. INFORMANT</b> ADDRESS Records- US PHS Hospital, Balto, Md.					
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> Hours Weeks Months	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia				(B) Intracranial hemorrhage DUE TO, OR AS A CONSEQUENCE OF: Neuroblastoma	
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> 2		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) yes	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indify medical examined) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from Nov. 26 1971 to Dec. 22 1971 that (I) (we) last saw the deceased alive on Dec. 22 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> John T. Sutherland, M.D.				<b>23B. DATE SIGNED</b> 12/22/71	
<b>23C. PHYSICIAN'S NAME (Type)</b> John Sutherland, MD				<b>23D. ADDRESS</b> US PHS Hospital, Balto, Md.	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> Burial		<b>24B. DATE</b> 12-27-1971		<b>24C. NAME of CEMETERY or CREMATORY</b> Greenwood Memorial Park	
<b>24D. LOCATION</b> (City, town, or county) (State) Lower Burrell West Moreland Co., Penna.		<b>25A. DATE REC'D BY HEALTH DEPT.</b> DEC 29 1971			
<b>25B. NAME OF REGISTRAR</b> Howard H. Hubbard		<b>25C. FUNERAL DIRECTOR</b> ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 12028</b>	
L-232 71 12028					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOSEPH G. LAUKAITIS		December 26, 1971 3:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
00		4406 Garrison Blvd. Baltimore, Maryland 21215		Maryland 1510	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Medical Doctor		Self Employed		12-7-1902	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Casmir Laukaitis		Mary Bodgon		69	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		220-44-5265		Mrs. Alma D. Laukaitis, 4406 Garrison Blvd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410.91		Acute Coronary occlusion			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		C. V. Disease			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		Parkinsonism			
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan. 1970 to 26 Dec. 1971					
that (I) (we) last saw the deceased alive on Nov. 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Joseph E. Muse Jr.				12/27/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Joseph E. Muse, Jr.				Wilkins & Pine Heights Ave., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12-30-1971		Woodlawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 29 1971		Robert E. Fisher, Md.		Howard H. Hubbard, 4107 Wilkins Ave. 21229	
25D. LOCATION (City, town, or county) (State)		25E. ADDRESS			
Woodlawn, Maryland		21229			



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J-425 71 12029

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12029

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Robert T. Tolson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 25 71 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 2612 Maempel La. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 25 71 2:20 p.m.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 8-30-1898		10. AGE (In years last birthday) 73	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Joseph H. Tolson		E. STREET AND NUMBER 2612 Maempel La.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Care Taker		14B. KIND OF BUSINESS OR INDUSTRY Baltimore City	
15. MOTHER'S MAIDEN NAME Mary A. Norman		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 215-16-5577		18. INFORMANT Mrs. Sarah E. Krouse, 1145 Linden Ave. 21227	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-29-1971	
24C. NAME of CEMETERY or CREMATORY Stevensville Cemetery		24D. LOCATION (City, town, or county) (State) Stevensville, Maryland	
25A. DATE REC'D BY HEALTH DEPT DEC 29 1971		25B. NAME OF REGISTRAR Robert E. J. J. J.	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

030 177

2012 January 1

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Joseph A. Jones

U.S.A.

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-625		71 12030		BALTIMORE CITY HEALTH DEPARTMENT		71 12030	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Robert S Pearson				2. DATE AND HOUR OF DEATH 12/21/71 11:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital				A. STATE B. COUNTY Maryland St. Marys 6800			
				C. CITY OR TOWN Piney Pt.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER General Delivery			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/3/15	9. AGE (In years last birthday) 56	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Robert Person				14. MOTHER'S MAIDEN NAME Mary Campbell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 213 16 2433		17. INFORMANT Grace Barnes		
					ADDRESS Piney Point Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 153.0 NEPADOMA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) NEUROPTICIS DUE TO, OR AS A CONSEQUENCE OF:			
				(C).....			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/24/71 to 12/21/71 that (I) (we) last saw the deceased alive on 12/21/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Harold Haldeman, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/21/71	
23C. PHYSICIAN'S NAME (Type) J. Harold Haldeman, M.D.				23D. ADDRESS Johns Hopkins Hosp Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-23-71		24C. NAME of CEMETERY or CREMATORY St Lukes		24D. LOCATION (City, town, or county) (State) St George Island St Marys Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR E. J. ...		25C. FUNERAL DIRECTOR W.C. Mattingley, Leonardtown, Md. 20650			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">71 12031</span>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">71 12031</span>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
CARL GILBERT				12/17/71 12:01 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL				A. STATE MARYLAND			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY 1204			
C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 2008 CALVERT STREET							
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/71	9. AGE (in years last birthday) 41	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. <span style="font-size: 2em;">398X I</span> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE CARDIO RESPIRATORY ARREST			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) CONGESTIVE HEART FAILURE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
(C) RHEUMATIC HEART DISEASE							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				HEPATIC FAILURE			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/17/71 to 12/17/71 that (I) (we) last saw the deceased alive on 12/16/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ramon Del Busto MD				23B. DATE SIGNED 12/17/71		23C. PHYSICIAN'S NAME (Type) RAMON DEL BUSTO, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE 12-23-71		24C. NAME OF CEMETERY OR CREMATORY	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971				25B. NAME OF REGISTRAR Ramon Del Busto, MD.		25C. FUNERAL DIRECTOR ANATOMY BOARD OF MARYLAND	
JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD							

THE NATIONAL ARCHIVE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

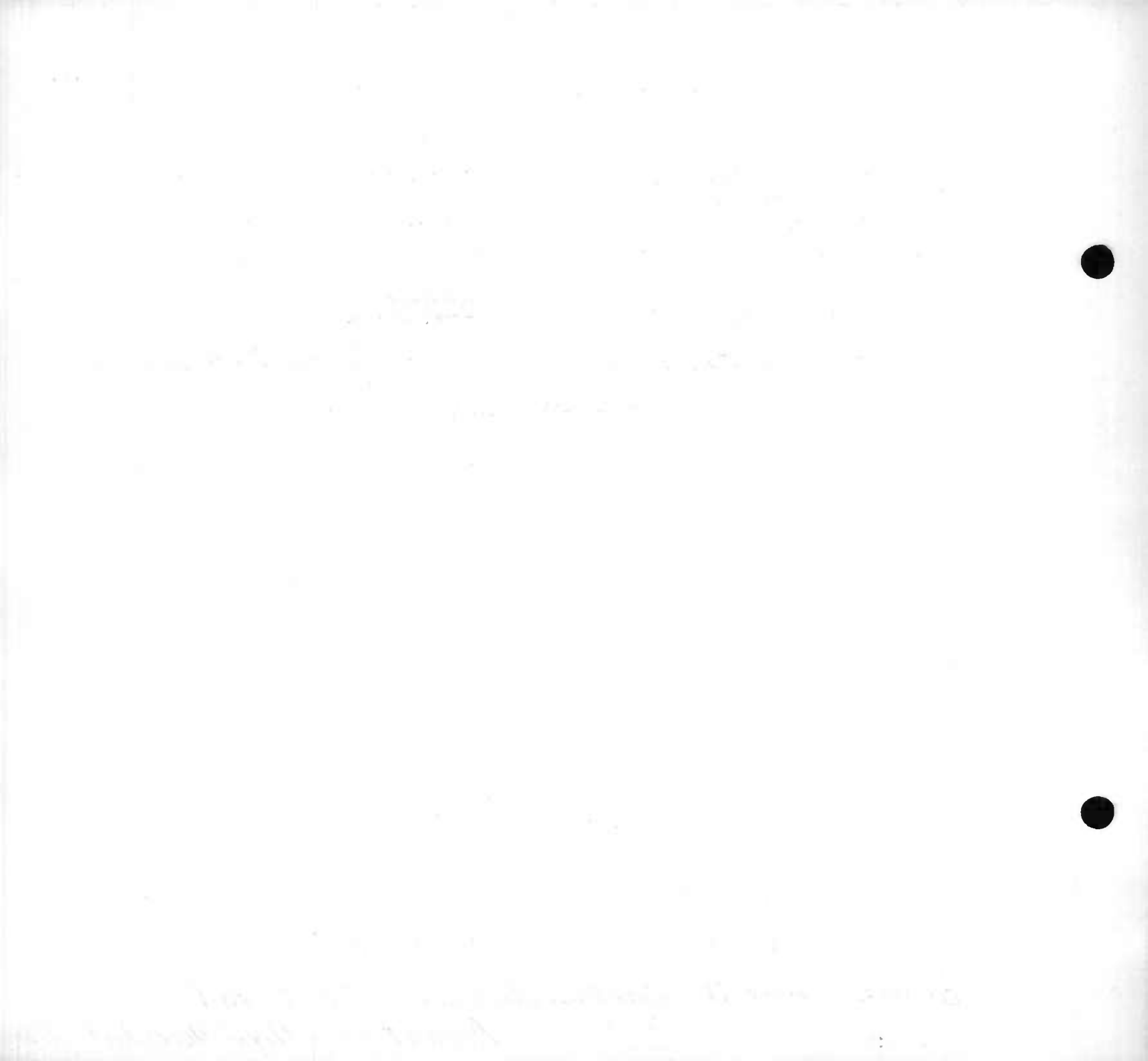
H-516 71 12032		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12032	
1. NAME OF DECEASED (Type or Print) <i>SARAH K. HENNEBERGER</i>		2. DATE AND HOUR OF DEATH <i>12-23-71 (3:55 am) 3:55 a.m.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND (CITY) BALTO</i> B. COUNTY <i>5300</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 UNION MEMORIAL HOSPITAL</i>		C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>DURLEY LANE</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>01-10-1905</i>	9. AGE (In years last birthday) <i>66</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED AT HOME</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>WALTER C. LIPS</i>			
14. MOTHER'S MAIDEN NAME <i>ELSIE M. BAILEY</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>			
16. SOCIAL SECURITY NO. <i>216-14-13917</i>		17. INFORMANT <i>Kenneth R. Henneberger - 417 Kensington Rd</i> <i>Mrs. Katherine Shouldice Dudley Lane</i>			
18. <i>153.31</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Dehydration</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Vomiting</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>6 days</i>	
		(C) <i>Abdominal Carcinomatosis - (sigmoid carcinoma)</i>		<i>5 months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>7-22-71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Large bowel obstruction</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12-20-1971</i> to <i>12-23-1971</i> that (I) (we) last saw the deceased alive on <i>12-22-1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Cesar A. Alegre MD</i>		23B. DATE SIGNED <i>12-23-71</i>		23C. PHYSICIAN'S NAME (Type) <i>CESAR A. ALEGRE MD</i>	
23D. ADDRESS <i>Union Memorial Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>			
24B. DATE <i>12-27-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 29 1971</i>		25B. NAME OF REGISTRAR <i>John A. ...</i>		25C. FUNERAL DIRECTOR <i>Amacost Funeral Chapel - 4608 Liberty Hgts</i>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

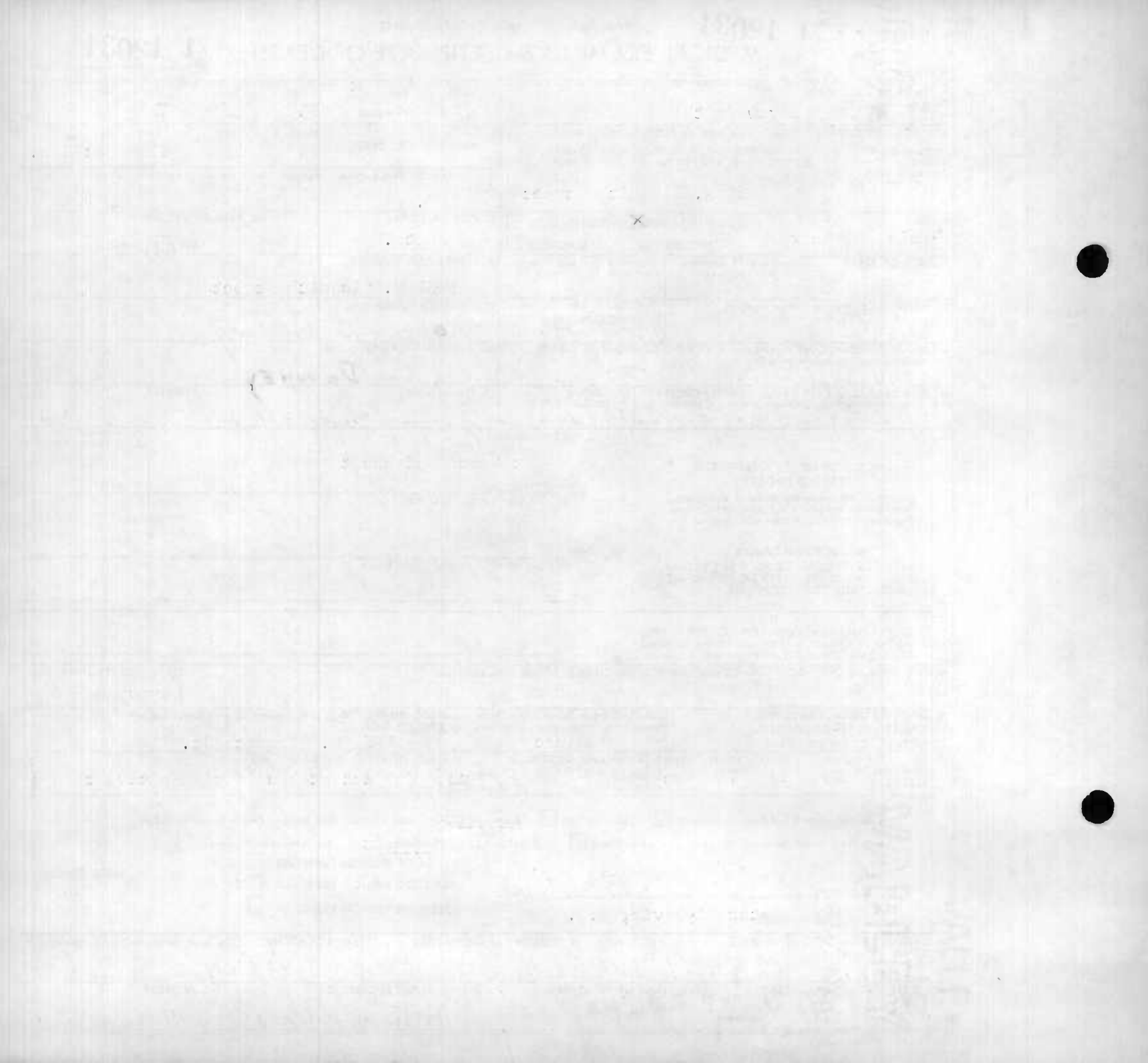
<p><b>B-320</b></p> <p>BIRTH NO. <b>71 12033</b></p>		<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>71 12033</b></p>	
<p>1. NAME OF DECEASED (Type or Print) <b>Sutch Mabel Irene</b></p>			<p>2. DATE AND HOUR OF DEATH <b>12/24/71</b> <b>8:10 a.m.</b></p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p>		
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Pleasant Manor Nursing Home 4615 Park Heights Avenue Baltimore Maryland</b></p>			<p>A. STATE <b>Baltimore</b> B. COUNTY <b>301</b> C. CITY OR TOWN <b>Balto. City</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>236 South Dallas Court</b></p>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/05</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown - Not Patient</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (State or foreign country) <b>Cumberland Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Unknown John Baldwin</b>			14. MOTHER'S MAIDEN NAME <b>Unknown Julia Dettelhauser</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>218-05-4438</b>		17. INFORMANT ADDRESS <b>Warren White 3401 Milford Avenue</b>
18. <b>4369 I</b> CAUSE OF DEATH					
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>			<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <b>CVA</b></p> <p>(C) <b>Severe Disorder</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b></p>
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>					
19A. DATE OF OPERATION <b>12/23/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>7/2/71</b> 19 to <b>12/24/71</b> 19</p> <p>that (I) (we) last saw the deceased alive on <b>12/23</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
23A. SIGNATURE <b>E. S. Kallins</b>			23B. DATE SIGNED <b>12/24/71</b>		
23C. PHYSICIAN'S NAME (Type) <b>Edward Kallins</b>			23D. ADDRESS <b>6611 Greenspring Avenue</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-28-71</b>		24C. NAME of CEMETERY or CREMATORY <b>BALTIMORE NATIONAL</b>	
24D. LOCATION <b>BALTO, MD</b>		24E. FUNERAL DIRECTOR <b>Amareost Funeral Chapel - 4606 Liberty Hgts</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>John E. Jones, M.D.</b>		25C. ADDRESS	



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S-5301 12034 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 71 12034  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Andrew Smith				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 25 71 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1051 N. Aisquith Street				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 25 71 8:12 a. M.			
6. SEX male				7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3-27-27				10. AGE (In years last birthday) 44		11. BIRTHPLACE (State or foreign country) N.C.	
12. CITIZEN OF U.S.A.				13. FATHER'S NAME Norman Smith		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	
15. MOTHER'S MAIDEN NAME Evelyn Downey				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO. 9-28-58-58-52				18. INFORMANT James Smith - 1116 N. Lorraine Ave.			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				20. DATE OF OPERATION 2			
21. AUTOPSY? (Yes or No) yes				22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House			
23. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1051 N. Aisquith St.				24. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12 25 71 unk m.			
25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				26. HOW DID INJURY OCCUR? Subject stabbed during altercation			
27. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				28. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
29. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				30. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
31. DATE SIGNED 12/25/71				32. ACTUAL SIGNATURE Peter Lipkovic, M.D.			
33. DATE REC'D BY HEALTH DEPT. DEC 29 1971				34. NAME OF REGISTRAR John E. Taylor, M.D.			
35. FUNERAL DIRECTOR Milton E. Fickson				36. ADDRESS 1129 N. Lorraine St.			





W-452 71 12035

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12035

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Walter Williams		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 25 Year 71 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2016 Ellsworth St.		3. DATE PRONOUNCED DEAD Month 12 Day 25 Year 71 Hour 9:20 p. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 807			
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 9-18-95	10. AGE (In years last birthday) 76	E. STREET AND NUMBER 2016 Ellsworth St.	
11. BIRTHPLACE (State or foreign country) VA.	12. CITIZEN OF U.S.A.	13. FATHER'S NAME Steven Williams	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Construction Worker		15. MOTHER'S MAIDEN NAME Cornelia Goodman	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I.		17. SOCIAL SECURITY NO. 218-09-4482	18. INFORMANT ADDRESS Elizabeth Williams-2016 Ellsworth St.
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 12-26-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/26/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-30-71	24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.	24D. LOCATION (City, town, or county) (State) A.A. County Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR ADDRESS Zorah T. Lichts on-1129 N. Caroline St.	

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71 12036		BALTIMORE CITY HEALTH DEPARTMENT		71 12036	
C-615		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
Montana CURBEAM		3. DATE PRONOUNCED DEAD Month Day Year 12 27 1971		Hour 12:27a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md.		B. COUNTY 804	
33 Johns Hopkins Hospital		6. SEX female		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 9-3-52		10. AGE (In years lost birthday) 19		E. STREET AND NUMBER 2214 Henneman Ave.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF U.S.A.		13. FATHER'S NAME Willie Blate Curbeam	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aide		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Corily Hill	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT Willie Curbeam - 2214 Henneman Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE Two gunshot wounds of chest DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) bar		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 2205 Mura St. 804	
22D. TIME OF INJURY (APPROX.) 12-27-71 12:15a.m.		22E. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-30-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT. DEC 29 1971		24F. NAME OF REGISTRAR Robert E. Fisher, M.D.	
24G. FUNERAL DIRECTOR Break J. Clifton - 11297 Cradock St.		24H. ADDRESS		24I. DATE SIGNED 12-27-71	

1901 JAN 12

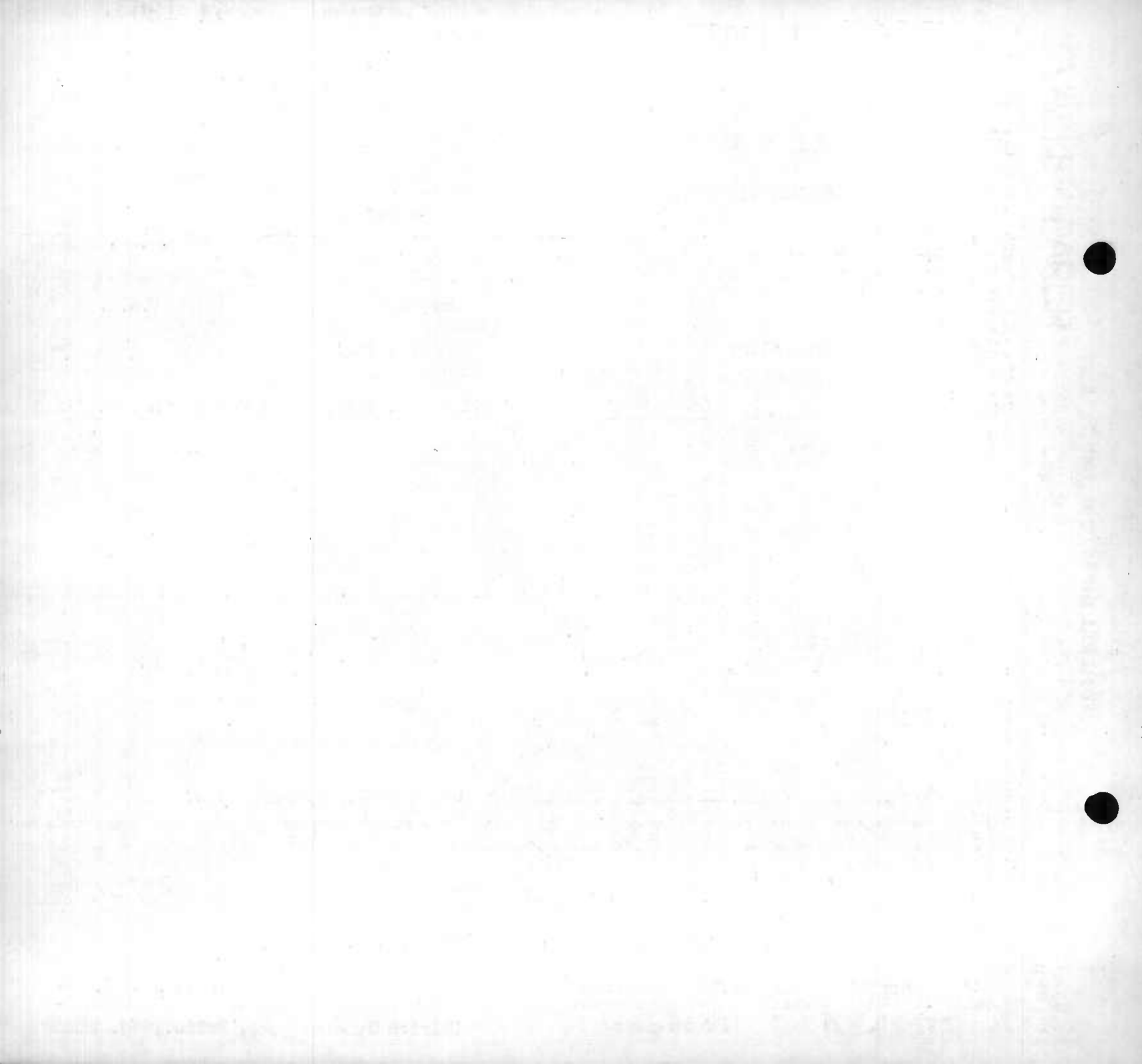
12

1901 JAN 12

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 12037
E-256 71 12037				REG. NO.
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BERTHA R. D. ECKMEYER</b>		2. DATE AND HOUR OF DEATH <b>15 December 1971 9:30 A M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>903</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 900 McKewin Ave.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>900 McKewin Ave.</b>		
5. SEX <b>Female</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 June 1891</b>	9. AGE (In years lost birthday) <b>80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Kline</b>		
14. MOTHER'S MAIDEN NAME <b>Jane Pugh</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>William H. Eckmeyer, 900 McKewin Ave. 21218</b>		
18. <b>412.1-250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Heart Disease</b> enlarged heart - Ch Congestive failure		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension, CVD</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>gentle arteriosclerosis</b> (C) <b>Diabetes Mellitus</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12-15</b>		
<b>II</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>July 1 1965</b> to <b>Dec 15 1971</b> , that (I) (we) lost saw the deceased alive on <b>Dec 1 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>D.W. Mintzer</b>		23B. DATE SIGNED <b>12/16/71</b>		23C. PHYSICIAN'S NAME (Type) <b>D.W. Mintzer, MD</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>18 Dec. 71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>
24D. LOCATION <b>Baltimore County, Md. 21224</b>		24E. FUNERAL DIRECTOR <b>Ullrich Funeral Home, Balto., Md. 21206</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, Md.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Ullrich Funeral Home, Balto., Md. 21206</b>

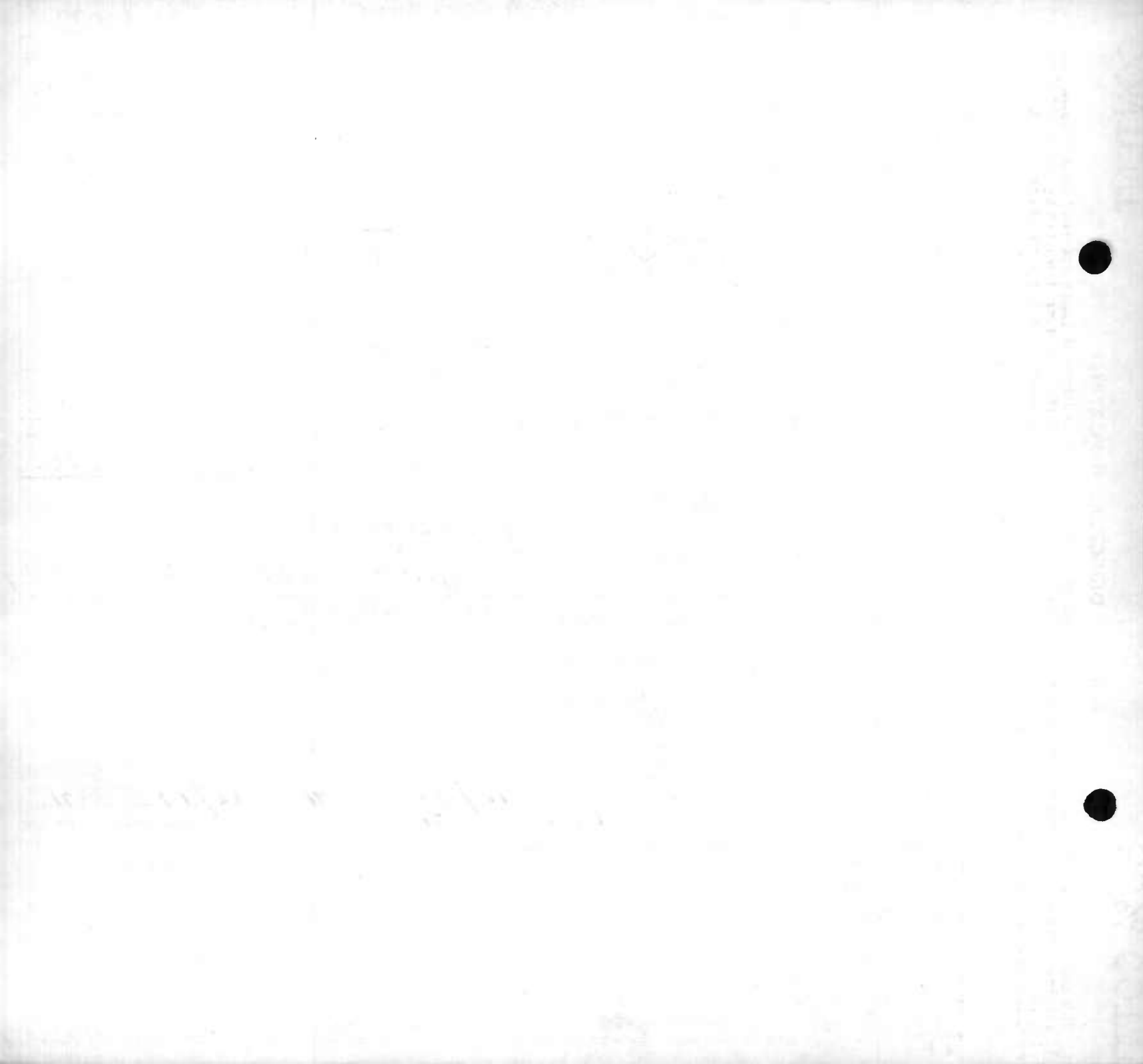




# FUNERAL DIRECTOR: IMPORTANT

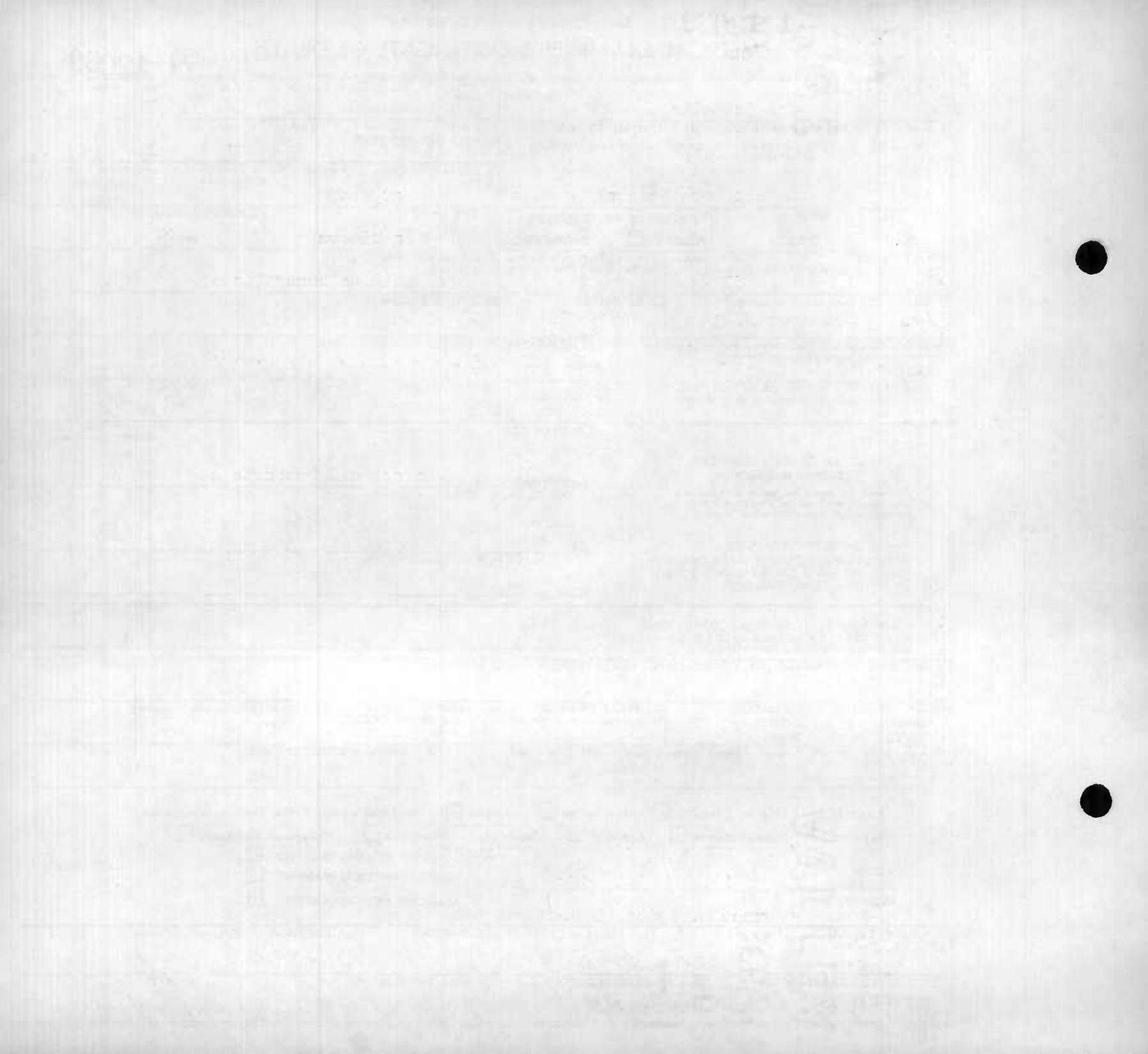
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>71 12038</u>	
BIRTH NO. <u>S-220 71 12038</u>		1. NAME OF DECEASED (Type or Print) <u>Sheuchik MARK N.</u>		2. DATE AND HOUR OF DEATH <u>12/17/71</u> <u>8<sup>15</sup> A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME &amp; HOSPITAL</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>BROADWAY &amp; FAYETTE ST.</u>		E. STREET AND NUMBER <u>231 Detroit Ave. 21222</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03-22-93</u>	9. AGE (in years last birthday) <u>78</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>UKRAINE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.S.R.</u>		13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>MARY NADRICLNA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-07-6400</u>		17. INFORMANT <u>KATHERINE JUPRIK. 11 LIBERTY PKWY. 21222</u>	
18. <u>174 X 1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Insufficiency - Lung failure</u> <u>Probable pulmonary embolism or thrombosis</u> (B) <u>Lung metastasis 2nd to Ca left Breast</u> (C) <u>congestive Heart failure - Pulmonary insufficiency</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>cerebral Arteriosclerosis - Pulmonary fibrosis</u> <u>status post mastectomy (left) - Lymphedema left arm</u>		19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/22</u> 19 <u>71</u> to <u>12/17</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) ( <del>not</del> ) view the body after death.					
23A. SIGNATURE <u>Ashwin Mehta MD</u>		23B. DATE SIGNED <u>12/17/71</u>		23C. PHYSICIAN'S NAME (Type) <u>DR. ASHWIN MEHTA MD</u>	
23D. ADDRESS <u>Church Home &amp; Hosp. Balto. 21231</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>20 DEC 71</u>	
24C. NAME of CEMETERY or CREMATORY <u>JACRED HEART CEMETERY</u>		24D. LOCATION (City, town, or county) <u>BALTO. CO., MD.</u>		24E. (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1971</u>		25B. NAME OF REGISTRAR <u>John E. Kelly Jr.</u>		25C. FUNERAL DIRECTOR <u>CHURCH FUNERAL HOME, DUNDALK MD</u>	





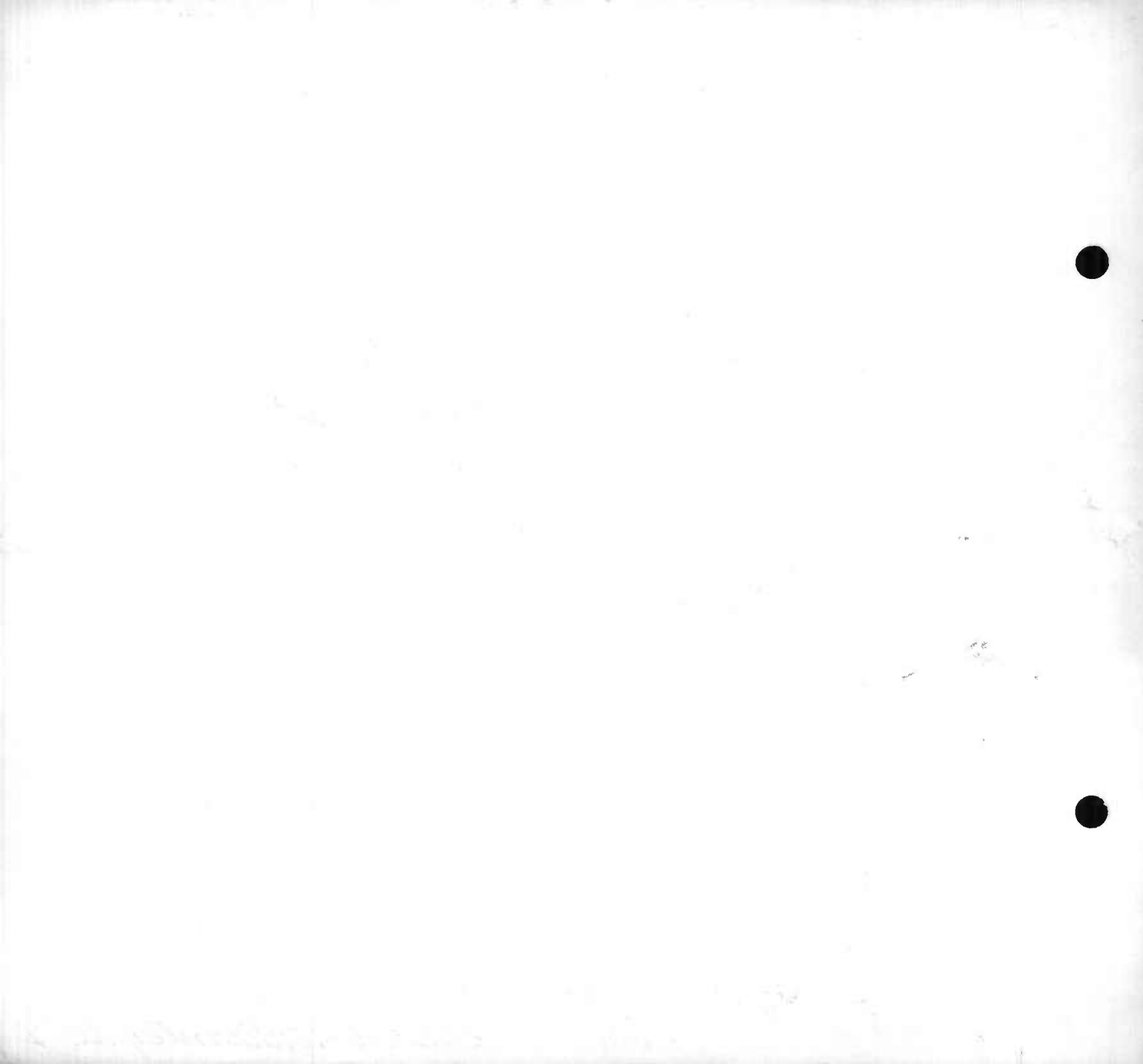
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-552		71 12040		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12040	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SIMMONS BEATRICE				2. DATE AND HOUR OF DEATH 12/26/71 10:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP. 42 OF BALTO.				A. STATE MD. BALTO		B. COUNTY 1511	
				C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3501 WABASH AVE #5			
5. SEX FEM	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/30/1887	9. AGE (in years last birthday) 84	10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Serris Pruitt			
14. MOTHER'S MAIDEN NAME Unknown				15. Was Deceased Ever In U.S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT Margaret Whitley			
18. 4361 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Vascular accident				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/24/71			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/25 1971 to 12/26 1971 that (I) (we) last saw the deceased alive on 12/25 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M.D.				23B. DATE SIGNED 12/26/71			
23C. PHYSICIAN'S NAME (Type) DAVID GLASER, M.D.				23D. ADDRESS SINAI HOSP. OF BALTO.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-29-71		24C. NAME of CEMETERY or CREMATORY Catholics Unit		24D. LOCATION (City, town, or county) (State) Catholics Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Catherine J. Brantley		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 71 12041

BIRTH NO. 71 12041

1. NAME OF DECEASED  
(Type or Print)

STELLA BALCEROWICZ

2. DATE AND HOUR OF DEATH

12-21-71 17:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Church Home Hospital  
100 N Broadway St  
Baltimore MD 21231

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

MD 102

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

602 S. ELLWOOD AVE

5. SEX

Female White

6. RACE

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

05-07-94

9. AGE (in years  
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Walter Balczynska

14. MOTHER'S MAIDEN NAME

Francis Bulezynska

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

A - son now Church Home Hosp

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

many years

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

ASCVD

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

None

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

None

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

None

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

None

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

None

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

None

22. I certify that (I) (this hospital) attended the deceased from 11-30 1971 to 12/21 1971 that (I) (we) lost saw the deceased alive on 12/21 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Sp. Merley MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

12/21/71

23C. PHYSICIAN'S NAME (Type)

GENA P. ENDOLOS MD

23D. ADDRESS

Church Home & Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/24/71

24C. NAME of CEMETERY or CREMATORY

Holy ROSARY Cem.

24D. LOCATION

Baltimore MD.

25A. DATE REC'D BY HEALTH DEPT.

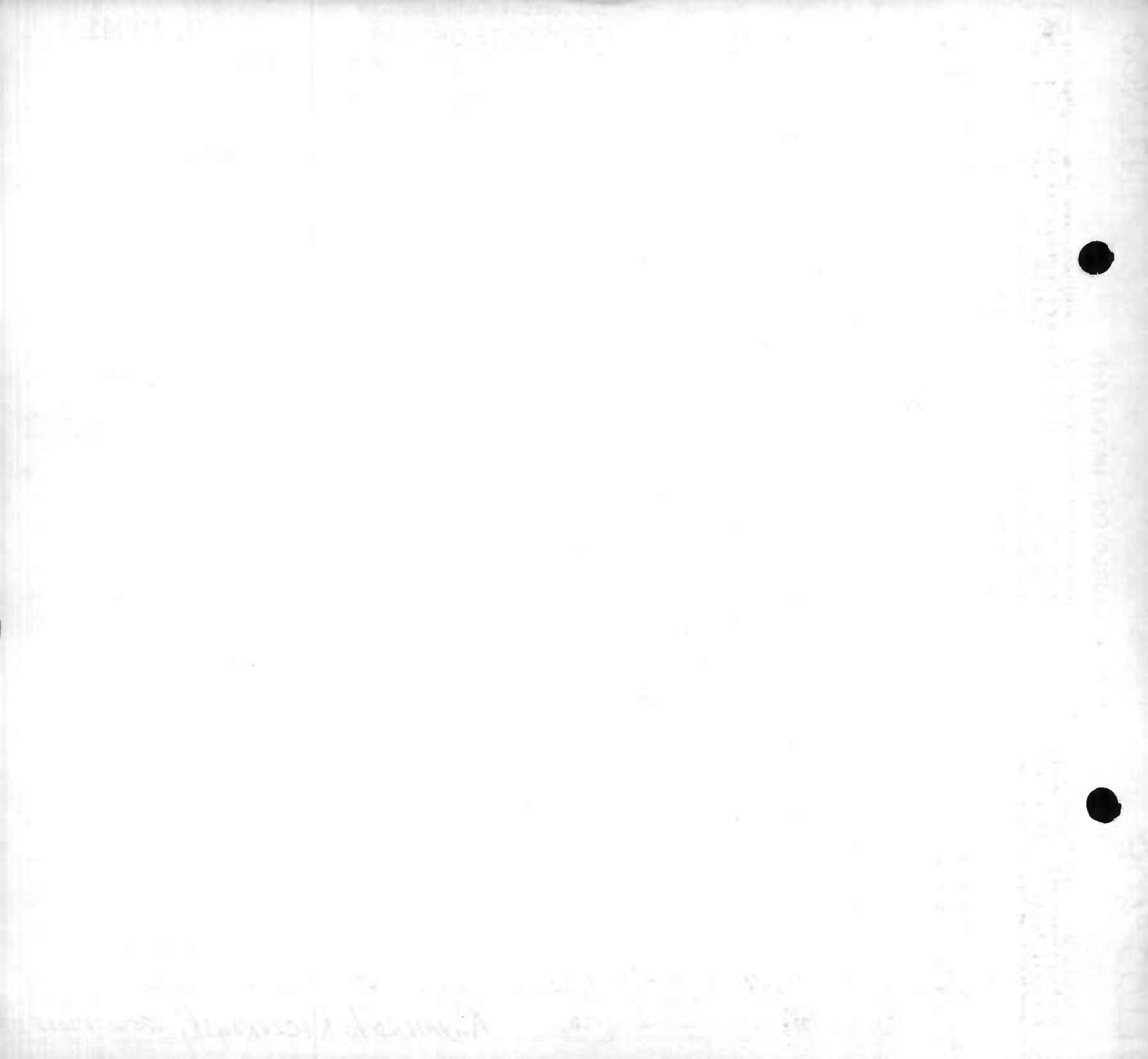
DEC 29 1971

25B. NAME OF REGISTRAR

John E. Jarboe MD

25C. FUNERAL DIRECTOR

RAYMOND H. KACZOROWSKI 2545 FLEET ST.



J-525

71 12042

BALTIMORE CITY HEALTH DEPARTMENT

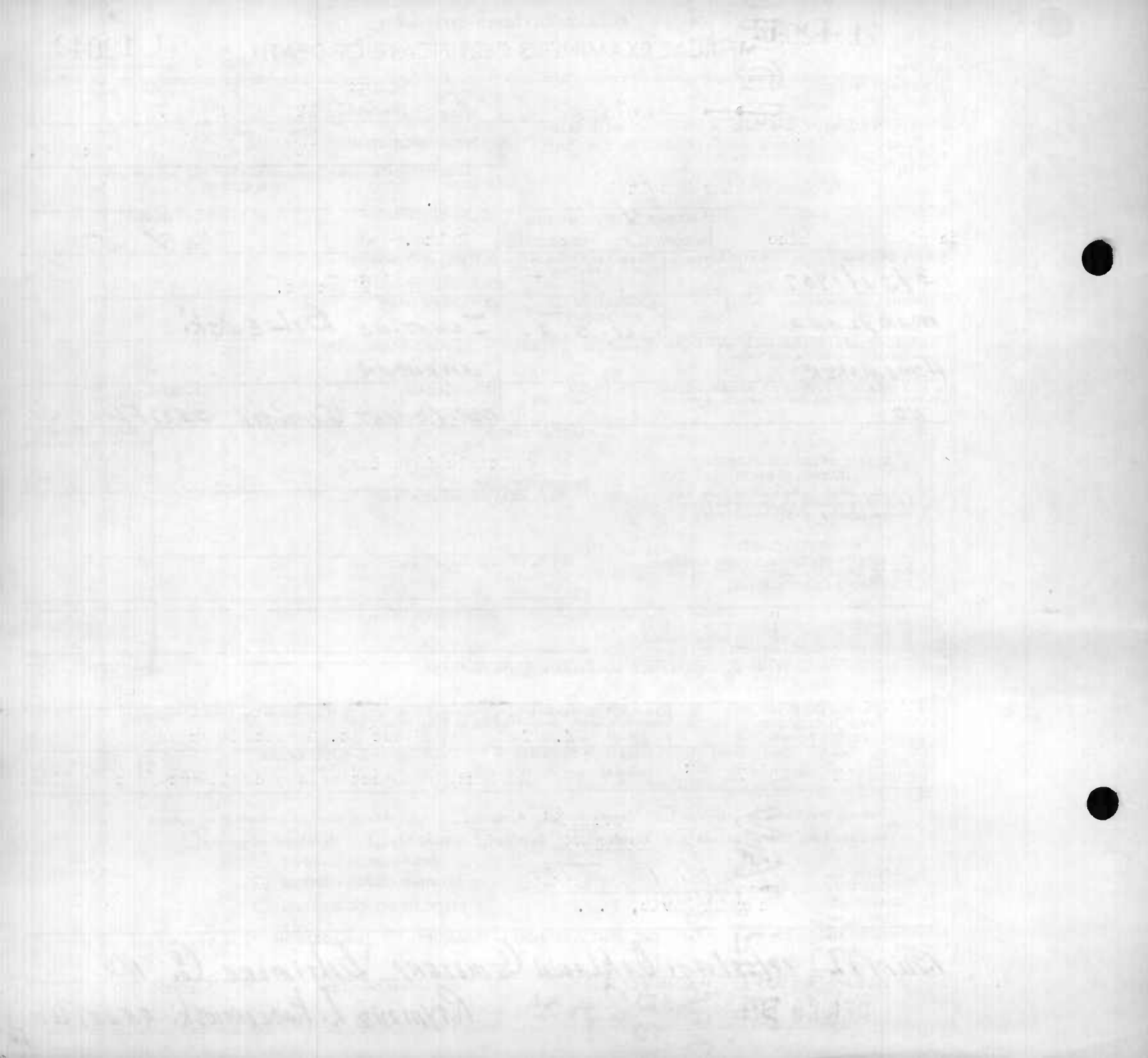
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12042

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Mary <del>Jamison</del> JAMISON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 23 71</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 John Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 23 71 8:30 p.m.</b>	
6. SEX <b>female</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>3/24/1907</b>		10. AGE (In years last birthday) <b>64</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>MR. ROBERT JAMISON</b>		ADDRESS <b>2509 FLEET ST.</b>	
19. CAUSE OF DEATH <b>E-812.1</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple injuries</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>STREET</b>	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>12 23 71 5:10 P.m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Fleet St. &amp; Milton Avenue</b>		22F. HOW DID INJURY OCCUR? <b>Subject passenger in auto/auto collision</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/28/1971</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>PAKLAWN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b>		ADDRESS <b>2525 FLEET ST.</b>	





BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		Natalie Edwards		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour 12 23 71 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET HOSPITAL, ADDRESS, OR INSTITUTION) Md. General Hospital		3. DATE PRONOUNCED DEAD		Month Day Year Hour 12 23 71 10:55p M.		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1403	
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	C. CITY OR TOWN		D. INSIDE CITY LIMITS?		
female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	Balto.		YES <input type="checkbox"/> NO <input type="checkbox"/>		
9. DATE OF BIRTH	10. AGE (In years lost birthday)	11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER			
6-8-1931	40	Baltimore, Maryland		1806 Madison Avenue			
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
U.S.A.		Nat Ailor		Counselor, Metropolitan Baltimore			
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
Mildred Smith		No		212-2-4843		Mildred Smith Ailor, 1031 Tiffany Ct.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Gunshot wound of chest		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C)							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)			
2				yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
Home		1806 Madison St.		1403			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?			
12 23-71 145		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Subject stabbed by unknown assailant Subject shot by unknown assailant			
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		Peter Lipkovic, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		12/24/71	
EXAMINER'S NAME (Type)				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-28-71		Mt. Auburn Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 29 1971		Robert E. Taylor, M.D.		Kenneth Law		4611 Park Heights Ave.	

1-6-72 - Letter from - Office of the Chief Medical Examiner, Peter Lipkovic, M.D.  
Assistant Medical Examiner

HRS

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 12044</u>
BIRTH NO. <u>L-340</u>		71 12044		
1. NAME OF DECEASED (Type or Print) <u>LITTLE, CHARLES P.</u>		2. DATE AND HOUR OF DEATH <u>12/19/71 9:40AM</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>804</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <u>2103 E. FEDERAL ST</u>		
5. SEX <u>male</u>	6. RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06/29/08</u>	9. AGE (in years last birthday) <u>63</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steelworker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rockingham, N.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Covington, Sally</u>		
14. MOTHER'S MAIDEN NAME <u>Little, JOHN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWII 3Sept42-14Oct42</u>		
16. SOCIAL SECURITY NO. <u>577 05 2328</u>		17. INFORMANT <u>Mary Little, 2103 E. Federal Street</u>		
18. <u>444.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>acute renal insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Embolus to Coronary V</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>28 days</u> <u>28 days</u> <u>28 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>atrial fibrillation 2° HASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>		
19A. DATE OF OPERATION <u>12-19-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>12-19-71</u> to <u>12-19-71</u> that (I) (we) lost saw the deceased alive on <u>12-19-71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Walter Motton Mally MD.</u>		23B. DATE SIGNED <u>12/19/71</u>		23C. PHYSICIAN'S NAME (Type) <u>DRR, WALTER M. MALLY</u>
23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>12/23/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Carver Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Kenneth Law</u>
25D. ADDRESS <u>4611 Park Heights Ave.</u>				



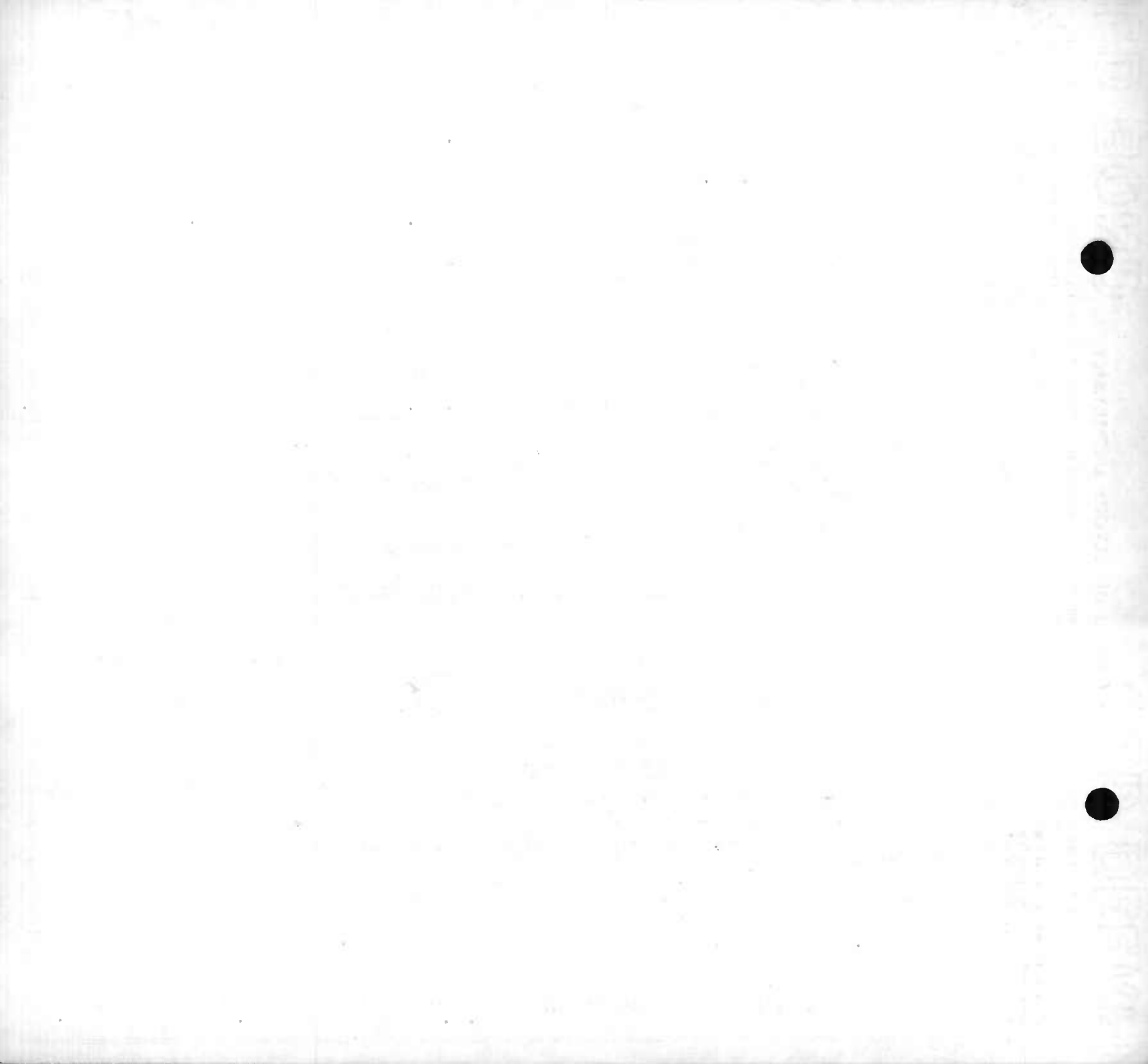
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **71 12045**

BIRTH NO. <b>71 12045</b>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <b>71 12045</b>	
1. NAME OF DECEASED (Type or Print) <b>Genevieve Chambers</b>			2. DATE AND HOUR OF DEATH <b>12-26-71 8<sup>00</sup> A M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Edgewood N. H.</b>			A. STATE <b>Md.</b> B. COUNTY <b>1202</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>311 E. University Pkwy.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-2-1894</b>	9. AGE (In years last birthday) <b>77</b>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert C. Boone</b>			
14. MOTHER'S MAIDEN NAME <b>Catherine McGregor</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>220-44-1170</b>		17. INFORMANT ADDRESS <b>Mrs. C. Leo Civish 1301 Southview Rd. 21218</b>			
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Disease</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic C.V. Dis.</b> (B) <b>Arteriosclerosis</b> (C) <b>Arteriosclerosis</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>12/26/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>11/30</b> 19 <b>71</b> to <b>12/26</b> 19 <b>71</b> that (X) (we) last saw the deceased alive on <b>12/26</b> 19 <b>71</b> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Anthony F. Carozza MD</b>				23B. DATE SIGNED <b>12/27/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Anthony F. Carozza</b>				23D. ADDRESS <b>5217 York Rd. Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-28-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>DEC 29 1971</b>			
25B. NAME OF REGISTRAR <b>J. W. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Sons Co. 4905 York Rd. Baltimore, Maryland 21212</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 12046	
<div style="display: flex; justify-content: space-between;"> <span>71 12046</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Caroline K. Jurgens		Dec. 27, 1971 5:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
90 Long Green Nursing Home			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			4403 Marble Hall Road 21218		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-2-1897	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Homemaker			Own Home		Maryland
12. CITIZEN OF WHAT COUNTRY?			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George Mattes			Clara M. Zander		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			220-46-6832		Mr. Richard Jurgens
					ADDRESS
					Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			Anteriosclerotic heart disease 6-0		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			Anteriosclerosis generalized P. yr.		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Nov 56 to 12/27 1971 that (I) last saw the deceased alive on 12/26 1971 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Norman R. Freeman				12/29/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Norman R. Freeman				11 W. 29th Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12-30-71		Moreland Memorial Park	
				Balto., Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 29 1971		V. E. Taylor, M.D.		H. W. Jenkins & Sons Co.	
				ADDRESS	
				4905 York Road Balto., Md. 21212	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
71 12047 BIRTH NO.					71 12047 REG. NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
CURRY, LOLA					12-29-1971 at 1:15 a.m.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE B. COUNTY				
Lutheran Hospital of Md.					MARYLAND BALTD 5300				
46					C. CITY OR TOWN		D. INSIDE CITY LIMITS?		
					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER				
					3424 DAYTON DR.				
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)	
Female		Negro				4-21-1894		77 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOMEWIFE				HOME		SOUTH CAROLINA		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
WILLIAM MACH					CARRIE ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO						MRS. MAE F. MOODY 3424 DAYTON DR.			
18. 422.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
ANTECEDENT CAUSES					Congestive Cardiac failure.				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) Acute abdomen.				
(C) _____					DUE TO, OR AS A CONSEQUENCE OF:				
II					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW OLD INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
J. Sampat M.D.					12-29-1971				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
J. SAMPAT.					Lutheran Hospital of Md.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		1-4-71		ARBORETUS MEM. PK.		BALTD. Co.; MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS			
DEC 29 1971			Robert E. Taylor, M.D.			NUTTER FUNERAL HOME 3035 W. NORTH AVE.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MEDICAL CERTIFICATION

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>71 12048</b></p>	
<p>BIRTH NO. <b>71 12048</b></p>		<p>DATE AND HOUR OF DEATH <b>12/29/71 3:10A.M.</b></p>	
<p>1. NAME OF DECEASED (Type or Print) <b>THOMAS POLLACK SR.</b></p>		<p>2. DATE AND HOUR OF DEATH <b>12/29/71 3:10A.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL, BALTIMORE, MD 21216.</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <b>MD</b> B. COUNTY <b>1608</b></p>	
<p>5. SEX <b>MALE</b> 6. RACE <b>NEGRO</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>2-19-19</b> 9. AGE (In years last birthday) <b>52</b></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER.</b></p>		<p>11. BIRTHPLACE (State or foreign country) <b>ARKANSAS</b></p>	
<p>10B. KIND OF BUSINESS OR INDUSTRY <b>Board of Education</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA.</b></p>	
<p>13. FATHER'S NAME <b>John Pollack</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>MARY Williams</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b></p>		<p>16. SOCIAL SECURITY NO. <b>215-05-8692</b></p>	
<p>17. INFORMANT <b>MRS Viola M Pollack</b></p>		<p>ADDRESS <b>3800 Rokeby Rd</b></p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE <b>BRONCHOGENIC CARCINOMA</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>	
<p>19A. DATE OF OPERATION <b>12/28/71</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TO VISUALISE EXTENT OF BRON. CA</b></p>	
<p>20A. AUTOPSY? (Yes or No) <input type="checkbox"/></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examination) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>12/23/1971</b> to <b>12/29/1971</b> that (I) (we) last saw the deceased alive on <b>12/29/1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Agus Cadar</b></p>		<p>23B. DATE SIGNED <b>12/29/71</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>AZAD CADAR</b></p>		<p>23D. ADDRESS <b>LUTHERAN HOSPITAL, BALTO, MD 21216</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b></p>		<p>24B. DATE <b>1-3-72</b></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <b>WESTERN STAR CEMETERY</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b></p>		<p>25B. NAME OF REGISTRAR <b>Robert E. Fisher, MD.</b></p>	
<p>25C. FUNERAL DIRECTOR <b>HERBERT E. NUTTER</b></p>		<p>ADDRESS <b>FUNERAL HOME 3035 W North Ave</b></p>	

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0903

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12049</u>	
BIRTH NO. <u>71 12049</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MASON, JOSEPH</u>			2. DATE AND HOUR OF DEATH <u>12-23-71</u> <u>6:45 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSP. OF BALTIMORE, INC.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE _____ B. COUNTY _____  C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2944 Edgewood Dr North</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-08</u>	9. AGE (In years last birthday) <u>63</u>	10. Under 1 Yr. Months _____ Days _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Md.</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James Mason</u>			14. MOTHER'S MAIDEN NAME <u>Emma Campbell</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. _____		
17. INFORMANT <u>Edna Mason</u>			ADDRESS <u>same</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>402X125017</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes Mellitus</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Metabolic Acidosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Chronic Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Hypertensive Heart Disease</u>  <u>Diabetes Mellitus</u>		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		
20A. AUTOPSY? (Yes or No) _____			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? _____		
22. I certify that (I) (this hospital) attended the deceased from <u>11-26</u> 19 <u>71</u> to <u>12-23</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12-23</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gerardo C. Gerasimo, M.D.</u>			23B. DATE SIGNED <u>12-23-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>VENERANDA C. GERASIMO</u>			23D. ADDRESS <u>Sinai Hosp - of Balt., Inc.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>12-29-71</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>			24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Saker, M.D.</u>		
25C. FUNERAL DIRECTOR <u>Kelson F.H.</u>			ADDRESS <u>1348 Calhoun Street</u>		



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12050

REG. NO. 71 12050

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Isaac Hymes

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐Month  
Day

Year

Hour

12

27

71

8:25 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Maryland General Hospital

3. DATE  
PRONOUNCED DEADMonth  
Day

Year

Hour

12

27

71

8:25 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1403

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

7-12-04

10. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

608 Waltermeyer Court

11. BIRTHPLACE (State or foreign country)

Illinois

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Hymes

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

retired

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Amanda Coleman

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Sadie Hughes-sister 2436 Linden Ave.

19.

412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular  
DUE TO, OR AS A CONSEQUENCE OF: disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

0

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-28-71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-31-71

24C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Pk.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 29 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

V. Bailey  
Kelson F.H. 1348 Calhoun Street

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 12051</u>	
BIRTH NO. <u>71 12051</u>		1. NAME OF DECEASED (Type or Print) <u>VERNON MORRIS</u>		2. DATE AND HOUR OF DEATH <u>12/27/71</u> <u>5:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1501</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>5/18/97</u> 9. AGE (in years last birthday) <u>74</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
11. BIRTHPLACE (State of foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Solomon Morris</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Wash</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218016727</u>		17. INFORMANT <u>Onnie Morris</u> ADDRESS <u>1531 Woodyear St.</u>	
18. <u>59901</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>STAPH. SEPTICEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>URINARY TRACT INFECTION</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>LEGTHOWERHOPE PNEUMONIA</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>W</u> (this hospital) attended the deceased from <u>12/20</u> 19 <u>71</u> to <u>12/27</u> 19 <u>71</u> that <u>W</u> (we) last saw the deceased alive on <u>12/27</u> 19 <u>71</u> and that <u>W</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>W</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Salvatore R. Donohue M.D.</u>		23B. DATE SIGNED <u>12/28/71</u>		23C. PHYSICIAN'S NAME (Type) <u>SALVATORE R. DONOHUE M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-31-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1971</u>		25B. NAME OF REGISTRAR <u>E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Geo. E. Bailey</u> ADDRESS <u>1348 Calhoun St.</u>	

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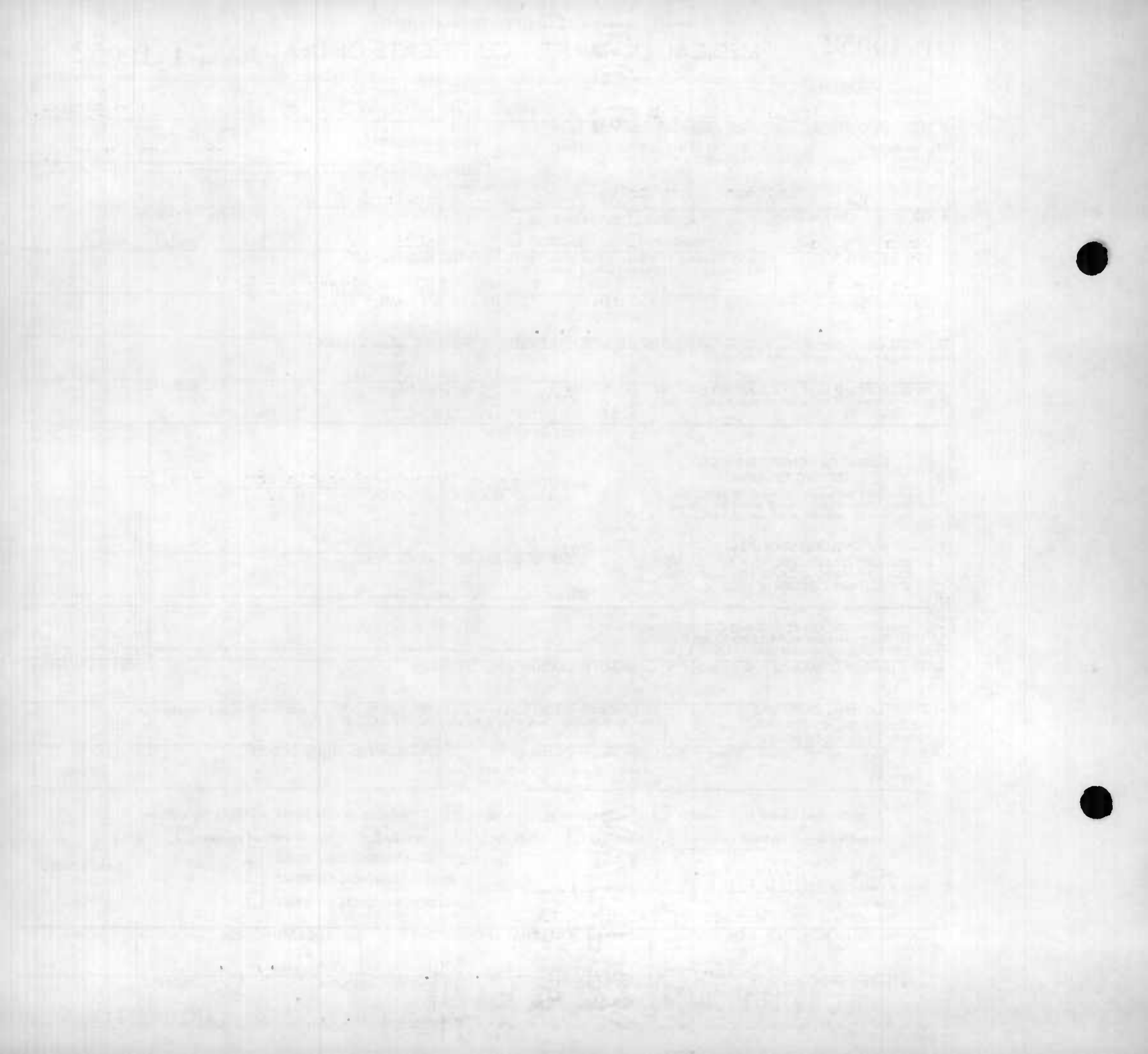
70

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12052

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Lawrence Snowden</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 27 71 3:20 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 27 71 3:20 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>12-17-15</b>		10. AGE (In years lost birthday) <b>56</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Mable Carter</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>214165586</b>	
18. INFORMANT <b>Mable Dare</b>		ADDRESS <b>same</b>	
19. CAUSE OF DEATH <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>No</b>	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12-28-71</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-31-71</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>V. Bailey</b>		ADDRESS <b>Kelson F.H. 1348 Calhoun Street</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12053</b>	
71 12053		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SIMPSON, DENNIS		12/27/71 7:35 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			Maryland C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			924 Whitlog Road		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	Negro		1/6/08	63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Machine operator		Heating plant		Spartanburg, S.C.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Edward Simpson			Addie Brutton		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 1/17/44 - 1/20/46		212-09-6106		VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			BENIGN PROSTATIC HYPERTROPHY		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from December 13th 1971 to December 27th 1971, that (2) (we) lost saw the deceased alive on December 27th 1971 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Meyer R. Heyman M.D.				December 28, 1971	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
MEYER R. HEYMAN M.D.				3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		Dec 31, 1971		Gettysburg Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 29 1971		Robert E. Fisher, M.D.		Williams Funeral Home 39 N. Howard St.	

924 WHITELOCK ST

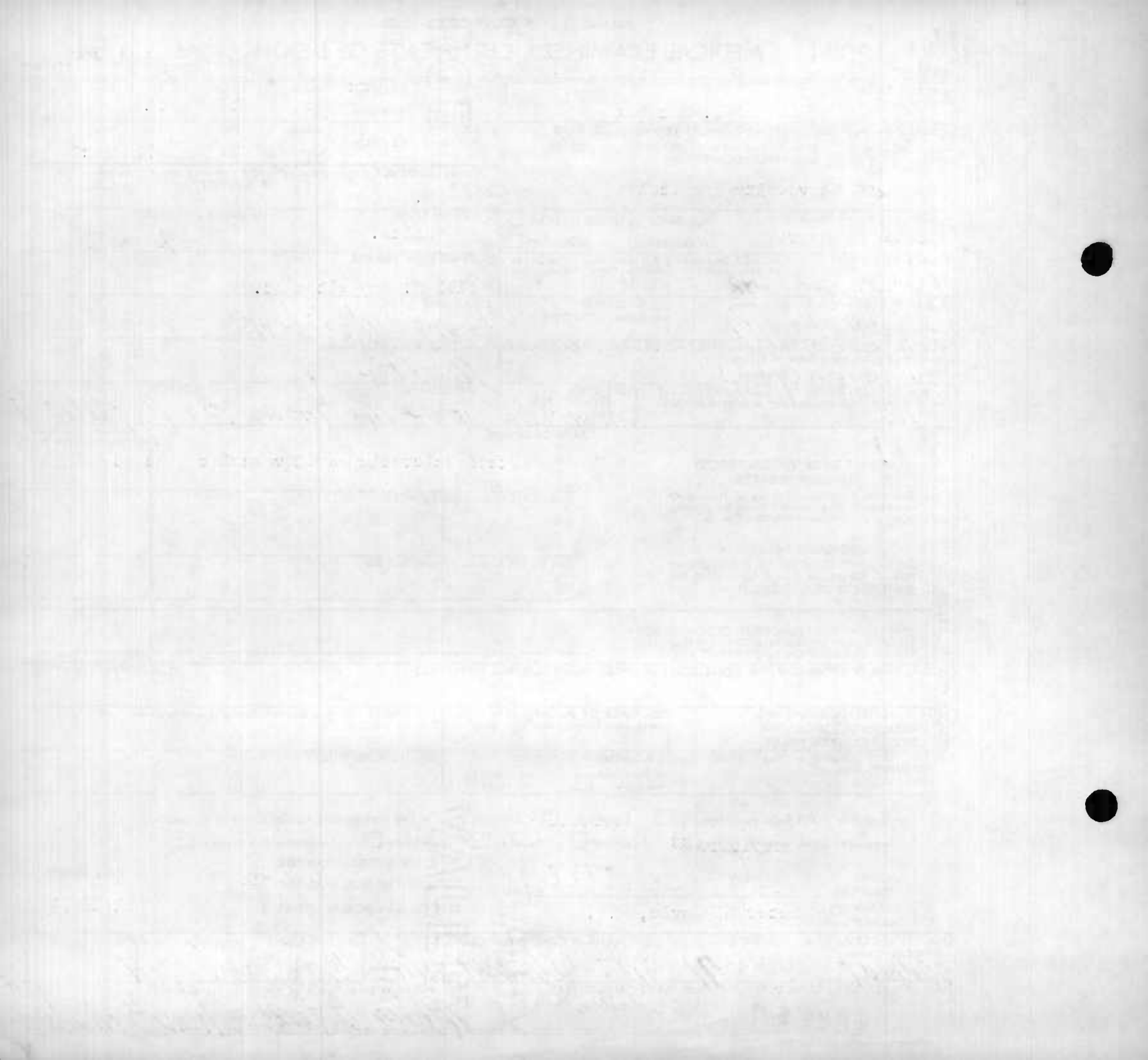
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William E. Mathews		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 24 71 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 24 71 11:30 p.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Dec. 24, 1893		10. AGE (in years lost birthday) 78	
11. BIRTHPLACE (State or foreign country) Laurel Md		12. CITIZEN OF WHAT COUNTRY? Henry Matthews	
13. FATHER'S NAME Henry Matthews		14. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1801	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		16. KIND OF BUSINESS OR INDUSTRY	
17. SOCIAL SECURITY NO. 218-04759A		18. MOTHER'S MAIDEN NAME Mattie	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) No		20. INFORMANT Anne Matthews	
21. ADDRESS 113 N. Poppelton St.		22. CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
24A. DATE OF OPERATION		24B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
25A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
25C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		25D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
25E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		25F. HOW DID INJURY OCCUR?	
26. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 12/25/71		27. BURIAL CREMATION, REMOVAL (Specify) Burial	
28. DATE 12/30/71		29. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.	
30. LOCATION (City, town or county) (State) Cedar Hill Md.		31. DATE REC'D BY HEALTH DEPT. DEC 29 1971	
32. NAME OF REGISTRAR Robert E. Tabor, R.D.		33. FUNERAL DIRECTOR Williams Funeral Home 399 N. Calhoun St.	







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71 12055

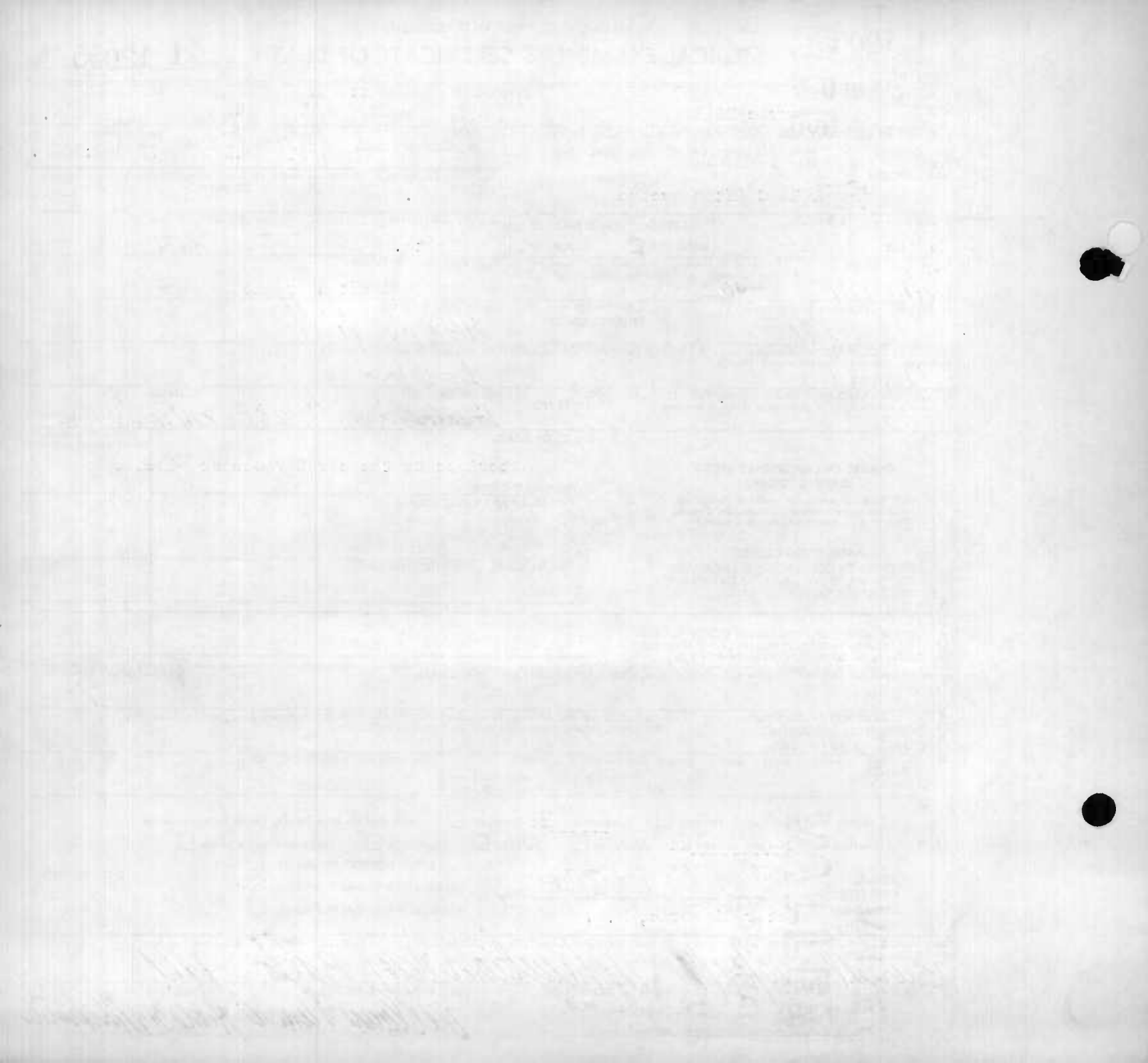
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12055

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Carrie Hill		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 23 71 4:50 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2824 Clifton Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 23 71 4:50 p.m.	
6. SEX female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH July 11, 1881		10. AGE (in years lost birthday) 90	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Henry Hill	
13. FATHER'S NAME Henry Hill		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	
15. MOTHER'S MAIDEN NAME Louise		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Gonzalo Smith 408 Normandy Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/29/71	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Gable, M.D.	
25C. FUNERAL DIRECTOR William Turner		25D. ADDRESS Home 3929 N. Howard St.	

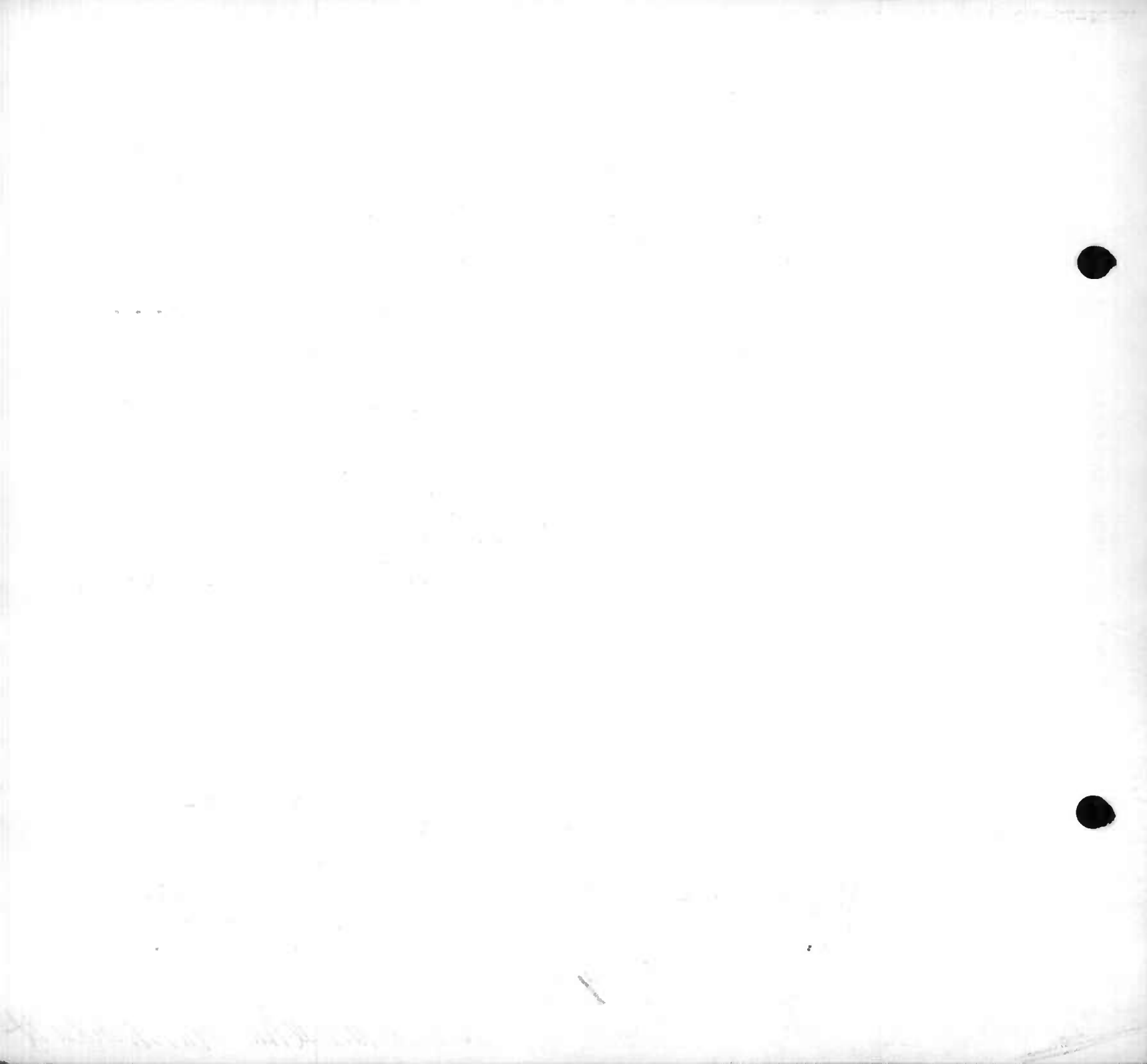


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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 12056		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12056	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BONS, ASTINA</b>		2. DATE AND HOUR OF DEATH <b>12/23/71 10:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1606</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		E. STREET AND NUMBER <b>2905 Arunah Ave 21216</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-19-1921</b>	9. AGE (In years lost birthday) <b>50</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland, Balto</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Powell</b>		14. MOTHER'S MAIDEN NAME <b>Verdell Smith</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records: BCH-4940 Eastern Avenue 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Anat</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Ce of Breast + Metastatic Ca</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>to lung, liver + bone</b> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>yes</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-18-</b> 19 <b>71</b> to <b>12-23-</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12-23-</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Wisneski</b>		23B. DATE SIGNED <b>12/23/71</b>		23C. PHYSICIAN'S NAME (Type) <b>J. Wisneski</b>	
23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/28/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Luke's</b>	
24D. LOCATION <b>Balto Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home 399 N. Broadway St</b>	



71 12057

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12057

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WALTER JAMES HALL</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1023 N. Wolfe St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 26 1971 4:15 p.m.</b>	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 11/27/		10. AGE (In years lost birthday) 19 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Detroit Mich.		12. CITIZEN OF WHAT COUNTRY? U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Edna McClenden		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 214-36-3165		18. INFORMANT Mrs Rebecca Saunders, 1316 Chester	
19. <b>485 X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute bronchopneumonia complicating intravenous narcotism</b> <b>Intravenous narcotism</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-27-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/71	
24C. NAME OF CEMETERY or CREMATORY Mt Calvary C metry		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W north Ave	

1-13-1972 - Letter from - Office of the Chief Medical Examiner, Russell S. Fisher, M.D.  
Chief Medical Examiner

HRS

1-26-1972 - Letter from - Office of the Chief Medical Examiner, Russell S. Fisher, M.D.  
Chief Medical Examiner

HRS

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12058

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

NAAMAH GOSSMAN (Grossman)

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Md.

B. COUNTY

1402

6. SEX

female

7. RACE

negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

4/28/50

10. AGE (In years  
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

540 Mechen St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

James Grossman

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

14B. KIND OF BUSINESS OR INDUSTRY

Hospital

15. MOTHER'S MAIDEN NAME

Dorothy

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

M's Deborah Nutter, 540 McMechen S

19.

304.91

CAUSE OF DEATH

Intravenous narcotism

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-27-71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/30/71

24C. NAME OF CEMETERY or CREMATORY

Mt Calvary C'metry

24D. LOCATION

(City, town, or county)

(State)

A A County Md

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 29 1971

Robert E. Fisher, M.D.

Adolphus Halstead 1206 W North Ave



2-10-1972 - Completion of cause of death on a pending medical examiner death certificate

Russell S. Fisher, M.D.

HRS



1. NAME OF DECEASED (Type or Print) MARK ZEPP		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 So. Balto. General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 26 1971 5:45p M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2505	
9. DATE OF BIRTH Nov 26 1957		10. AGE (in years last birthday) 14 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY none	
15. MOTHER'S MAIDEN NAME Janet A Zepp		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Janet A Zepp as above	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E9881 X Cranio-cerebral injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 21		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 4400 blk. 6th St.		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 12-25-71 1:01 a.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Unknown-probably beaten or hit by auto.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED 12-27-71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/71	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie Md, A A Co Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR McGuffey Funeral Home		ADDRESS 237 Patapsco Ave 21225	

1-11-1972 - Letter from - Office of the Chief Medical Examiner, Russell S. Fisher, M.D. (dt)  
Chief Medical Examiner

HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

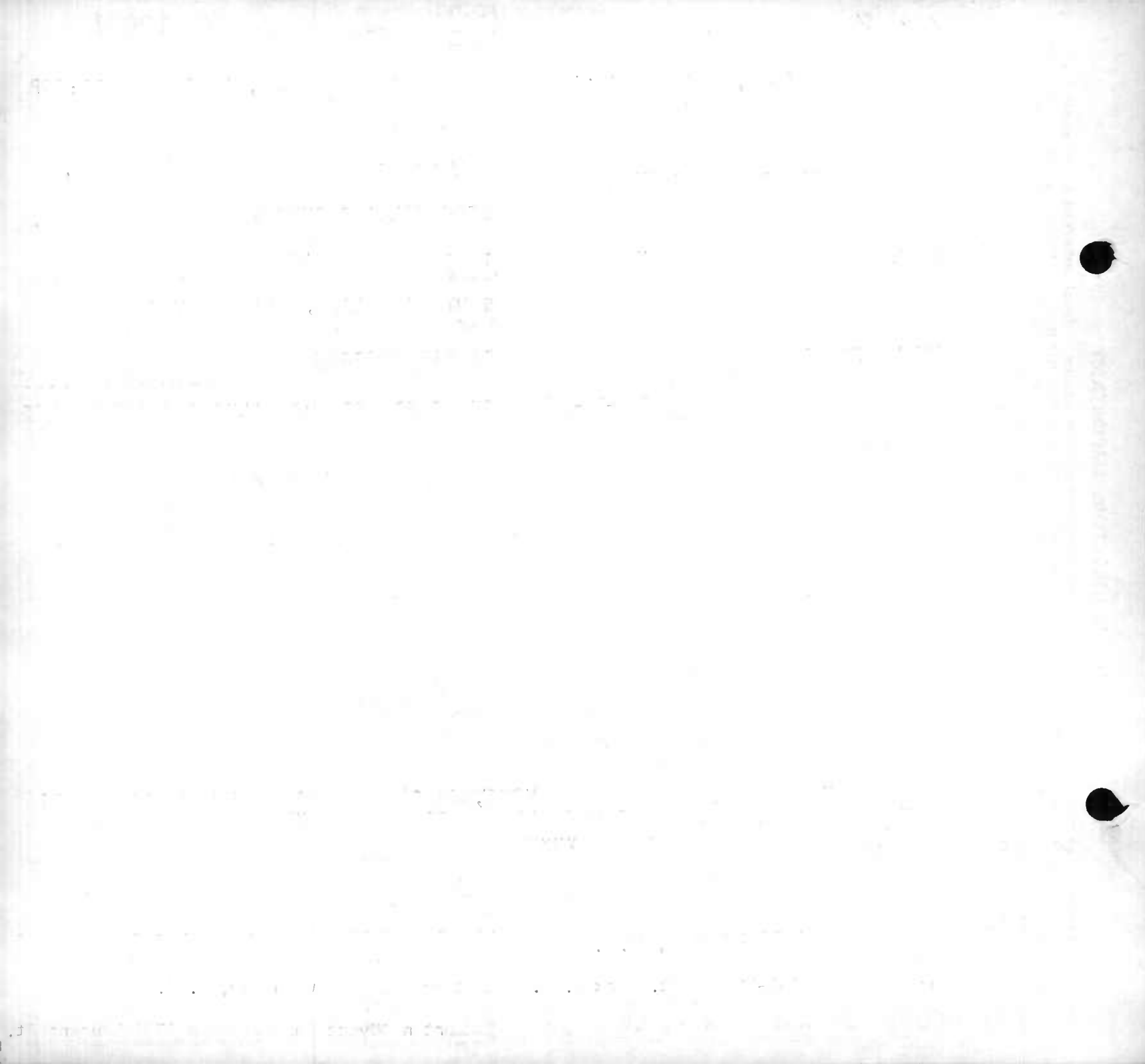
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12060</b>	
W-614 <b>71 12060</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Sarah Jane Warfield</b>		2. DATE AND HOUR OF DEATH <b>12/27/71 5:50 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Managers General Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> 8. COUNTY <b>Harford</b> <b>6200</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Managers General Hospital</b>		C. CITY OR TOWN <b>Forest Hill</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>Box 56 Jarrettsville Road</b>			
5. SEX <b>F</b>	6. RACE <b>CAUC.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-22-17</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas M. Fender</b>			
14. MOTHER'S MAIDEN NAME <b>Sarah Jane Edwards</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>217-14-1317</b>		17. INFORMANT <b>Ernest W. Warfield</b> ADDRESS <b>Box 56 Forest Hill, Md.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>5-7-1-1</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>21050</b> <b>year</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>UPON GF Hemorrhage</b> <b>21050</b> <b>year</b>			
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>WASTIC VARICES</b>		(C) DUE TO, OR AS A CONSEQUENCE OF: <b>Hepatic cirrhosis</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/25</b> 19 <b>71</b> to <b>12/27</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12/27</b> 19 <b>71</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Lloyd B. Mandel MD</b> DEGREE				23B. DATE SIGNED <b>12/27/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Lloyd B. Mandel MD</b> DEGREE				23D. ADDRESS <b>Managers General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/30/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Bel Air Mem. Gardens</b>	
24D. LOCATION <b>Bel Air, Harford, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>			
25B. NAME OF REGISTRAR <b>Charles E. Kurtz</b>		25C. FUNERAL DIRECTOR <b>Charles E. Kurtz</b> ADDRESS <b>21084 Jarrettsville, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12061</b>	
BIRTH NO. <b>71 12061</b>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>TAYLOR, MAGGIE EVANS</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 27, 1971 11:00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2004</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2505 HOLLINS STREET</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 15 22</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA, MANNING</b>	
13. FATHER'S NAME <b>IRVIN EVANS</b>		14. MOTHER'S MAIDEN NAME <b>CARRIE BROGGON</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>250-30-5516</b>		17. INFORMANT <b>BALTIMORE MD 21229</b> <b>ST AGNES RECORDS WILKENS &amp; CATON AVES</b>	
18. <b>199.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>metastatic papillary adenocarcinoma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>primary carcinoma not known</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>NOVEMBER 24</b> 19 <b>71</b> to <b>DECEMBER 27</b> 19 <b>71</b> that (2) (we) last saw the deceased alive on <b>DECEMBER 27</b> 19 <b>71</b> and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE <b>77 Mol</b>		23B. DATE SIGNED <b>12-28-71</b>		23C. PHYSICIAN'S NAME (Type) <b>JACOBUS MOL M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-2-72</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Mark A. M.E Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Clowden Cty, S. C.</b>		24E. ADDRESS <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVES</b>		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>		25B. NAME OF REGISTRAR <b>Reese, J. H. MD.</b>		25C. FUNERAL DIRECTOR <b>Morton &amp; Yett Funeral Home</b>	
25D. ADDRESS <b>1701 Laurens St.</b>		25E. ADDRESS		25F. ADDRESS	

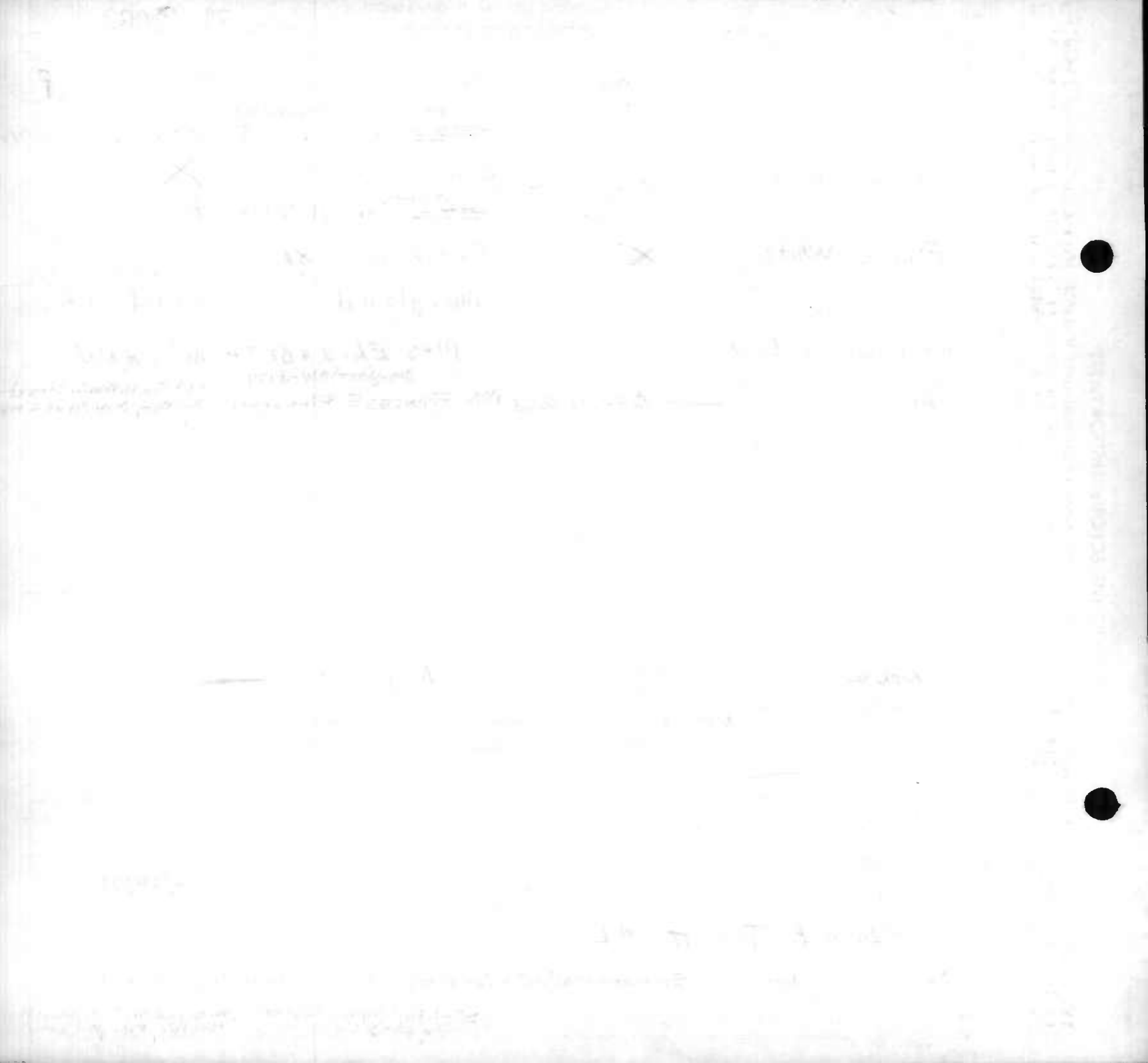


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. 71 12062

7-565 BIRTH NO. 71 12062		1. NAME OF DECEASED (Type or Print) <b>EU GENIE Moore FINNERAN</b>		2. DATE AND HOUR OF DEATH <b>December 28, 1971 7:40 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION Memorial Hospital</b> 44 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <b>119 S.</b> B. COUNTY <b>(Harford Co.)</b> <b>444 S Main Street Belair Md 21014</b> C. CITY OR TOWN <b>Belair md 21014</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>444 S Main Street 6232</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08-12-90</b>	9. AGE (in years last birthday) <b>81</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Mr Charles Dick</b>			14. MOTHER'S MAIDEN NAME <b>Mrs ELIZABETH MCCANN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-44-6653</b>		17. INFORMANT (Daughter) <b>838-3777</b> ADDRESS <b>119 South Main Street Belair, Maryland 21014</b>	
18. <b>238.1 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <b>Cardio Respiratory Sudden</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Brain Tumor, Lt. frontal ?</b> (B) <b>Pneumonia, left Sudden</b> DUE TO, OR AS A CONSEQUENCE OF: (C) —					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>A.S.C.V.D. Myocardial ischemia</b>					
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from <b>10/25/71</b> 19 to <b>12/28/71</b> 19 that (I) (we) last saw the deceased alive on <b>12/27/71</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edwin B. Jarrett, M.D.</b> DEGREE				23B. DATE SIGNED <b>12/28/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Edwin B. Jarrett M.D.</b> DEGREE		23D. ADDRESS <b>11 East Chase St., City 21202.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec.</b>		24C. NAME of CEMETERY or CREMATORY <b>Southern Methodist Cemetery</b>	
24D. LOCATION <b>Dublin, Harford Co., Maryland</b>		24E. FUNERAL DIRECTOR <b>Joseph Williams Foster</b> ADDRESS <b>W. Broad St. &amp; Williams St. Bel Air, Maryland 21014</b>		24F. DATE <b>DEC 30 1971</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 12063	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. 71 12063		1. NAME OF DECEASED (Type or Print) <u>Hattie Benedetta</u>			
2. DATE AND HOUR OF DEATH <u>12/28/71 2:45 AM</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. STATE <u>Maryland</u>			
6. CITY OR TOWN <u>Baltimore</u>		7. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
8. STREET AND NUMBER <u>823 S 50th St.</u>		9. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospital</u>			
10. SEX <u>Female</u>		11. RACE <u>Caucasian</u>		12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
13. DATE OF BIRTH <u>3/12/84</u>		14. AGE (In years last birthday) <u>87</u>		15. If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		17. KIND OF BUSINESS OR INDUSTRY		18. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
19. CITIZEN OF WHAT COUNTRY? <u>USA</u>		20. FATHER'S NAME <u>GEORGE TODD</u>		21. MOTHER'S MAIDEN NAME <u>Sophia</u>	
22. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		23. SOCIAL SECURITY NO. <u>2 16 07-4092</u>		24. INFORMANT <u>BCH Records: Baltimore, Md. 21224</u>	
25. CAUSE OF DEATH		26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Unknown</u>		DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) <u>Diabetes Mellitus</u>		DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
28. DATE OF OPERATION <u>2</u>		29. CONDITION FOR WHICH OPERATION WAS PERFORMED		30. AUTOPSY? (Yes or No) <u>Yes</u>	
31. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		32. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		33. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
34. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		35. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		36. HOW DID INJURY OCCUR?	
37. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> 19 <u>71</u> to <u>12/28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
38. SIGNATURE <u>S. Scharf</u>		39. DATE SIGNED <u>12-28-71</u>		40. PHYSICIAN'S NAME (Type) <u>S. Scharf M.D.</u>	
41. ADDRESS <u>Baltimore City Hospitals</u>		42. ADDRESS <u>4940 Eastern Ave. Baltimore, Md. 21224</u>		43. ADDRESS	
44. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		45. DATE <u>12/31/71</u>		46. NAME OF CEMETERY OR CREMATORY <u>CAMBRIDGE</u>	
47. LOCATION (City, town, or county) <u>CAMBRIDGE MD.</u>		48. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1971</u>		49. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
50. FUNERAL DIRECTOR <u>J. P. Connelly</u>		51. ADDRESS <u>300 N. Ave. Ave.</u>		52. ADDRESS	



Baltimore City Health Department				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 12064			
1. NAME OF DECEASED (Type or Print) <b>SCOTTY PENFIELD</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 25 Year 71 Hour 9:45 a. M.							
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 St. Agnes Hospital</b>				3. DATE PRONOUNCED DEAD Month 12 Day 25 Year 71 Hour 9:45 a. M.				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Howard</b> C. CITY OR TOWN <b>Ellicott City</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>3750 St. Paul Street</b>					
9. DATE OF BIRTH <b>April 24, 1971</b>		10. AGE (In years last birthday) <b>8 mo.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jerry Penfield</b>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				14B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		15. MOTHER'S MAIDEN NAME <b>Carolyn Mc Cormick</b>					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>None</b>		18. INFORMANT <b>Mr. Jerry Penfield, Father</b>		ADDRESS <b>Same # 5</b>					
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>795X1 Sudden death in infancy</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:							
20A. DATE OF OPERATION <b>7</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED						21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Peter Lipkovic, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/26/71</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec. 29/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Woodward Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Jonesville, Virginia</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>Fleming Funeral Service</b>		ADDRESS <b>Benson</b>		Md			

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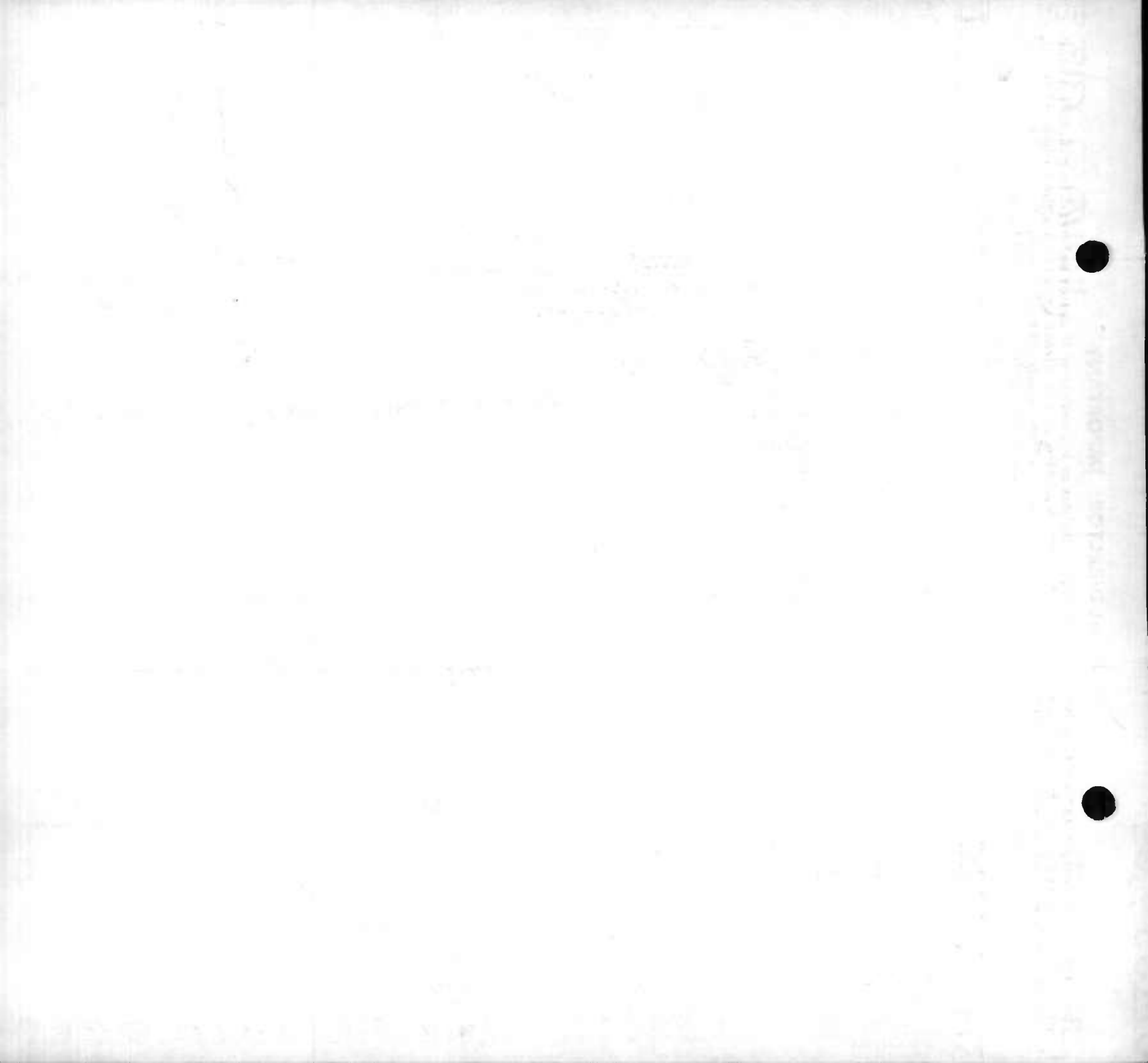
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

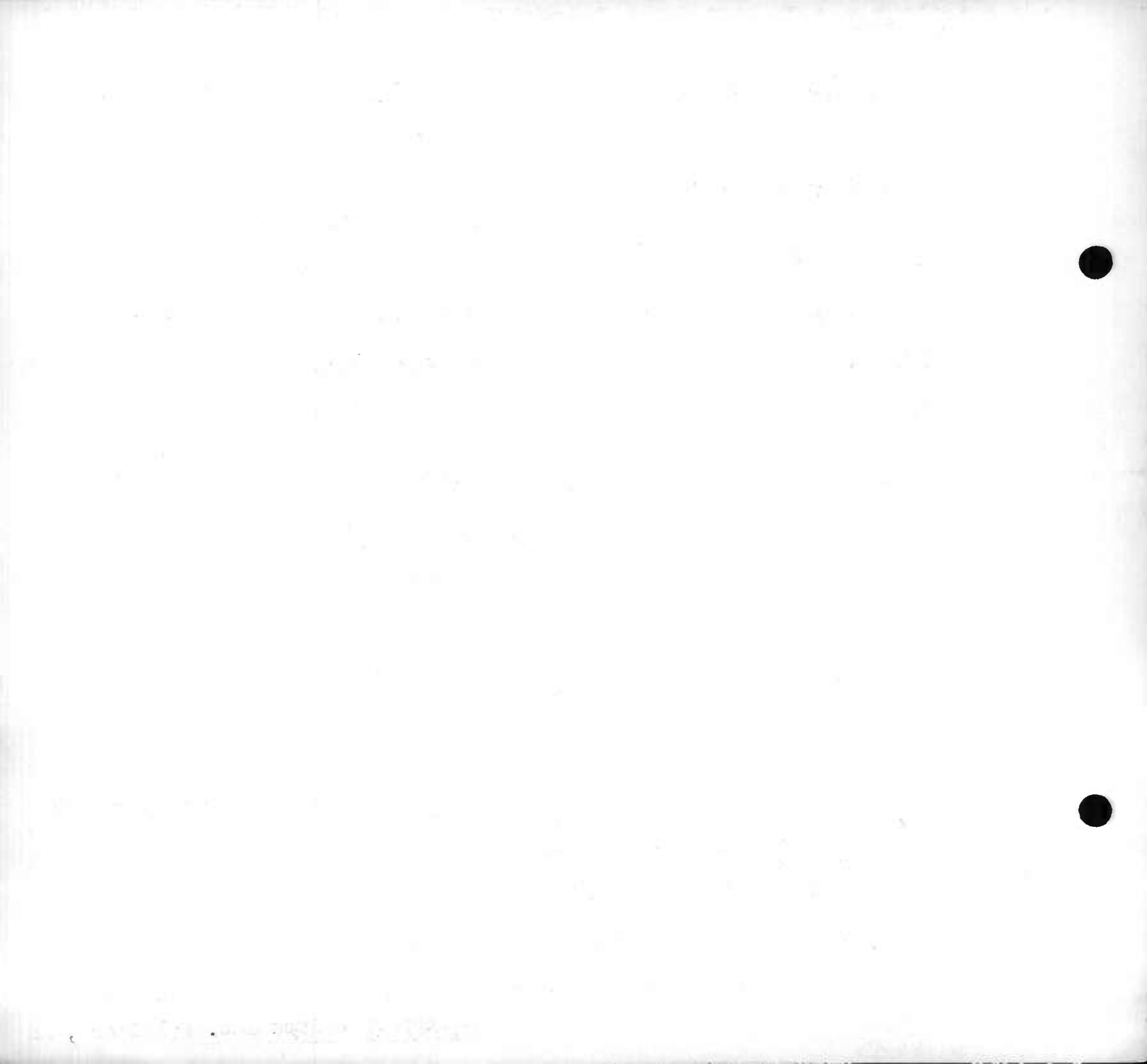
D-630 71 12065				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12065	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>DOHERTY, ROSE M.</u>				2. DATE AND HOUR OF DEATH <u>12-26-1971 7:20 AM.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2734</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3739 RASPE AVE</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <u>WIDOWED</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04-21-96</u>		9. AGE (In years last birthday) <u>76 75</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>SUPERVISOR - CROWN CORK &amp; SEAL CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>CHARLES E. DOHERTY</u>				14. MOTHER'S MAIDEN NAME <u>JANE OWENS?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-10-8217</u>		17. INFORMANT <u>MR. EDWARD CONROY</u>		ADDRESS <u>3739 RASPE AVE</u>	
18. <u>69321</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>SEPTICEMIA.</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>RENAL FAILURE.</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>HEART FAILURE.</u>				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-16</u> 19 <u>71</u> to <u>12-26</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12-26</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u> MD-DEGREE						23B. DATE SIGNED <u>12-26-1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>PERLOS A. BATTILONE MD</u>				23D. ADDRESS <u>UNION MEMORIAL HOSPITAL MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-29-71</u>		24C. NAME of CEMETERY or CREMATORY <u>MOST HOLY REDEEMER</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD.</u>		25C. FUNERAL DIRECTOR <u>J. Walter Conklin</u> ADDRESS <u>5444 BELAIR RD.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 12066</u>
BIRTH NO. <u>71 12066</u>		1. NAME OF DECEASED (Type or Print) <u>DALLAS POE RANEY</u>		
2. DATE AND HOUR OF DEATH <u>DECEMBER 28, 1971 1030 P.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>ARKANSAS</u> B. COUNTY <u>V03</u>		C. CITY OR TOWN <u>LITTLE ROCK</u>		
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>6 Longfellow Cir</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-9-07</u>	9. AGE (in years last birthday) <u>64</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BROKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>FINANCE</u>		11. BIRTHPLACE (State or foreign country) <u>NEWARK</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>THOMAS J.</u>		
14. MOTHER'S MAIDEN NAME <u>INEZ BRANNON</u>		15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>7</u>		17. INFORMANT <u>Hx - Relatives</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>SEPTIC SHOCK</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hr.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>UNDETERMINED SOURCE</u>		(B) <u>UNDETERMINED SOURCE</u>		
(C) <u>LIPOSARCOMA</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>12-17-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PELVIC MASS</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <u>12-01</u> 19 <u>71</u> to <u>12-28</u> 19 <u>71</u> that (2) (we) last saw the deceased alive on <u>12-28</u> 19 <u>71</u> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>12/29/71</u>		23C. PHYSICIAN'S NAME (Type) <u>FRANCISCO JOSE NEGR</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/30/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ROSELAWN-MEM-GARDEN</u>
24D. LOCATION <u>LITTLE ROCK ARKANSAS</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Buck, Inc.</u>		
25D. ADDRESS <u>Baltimore, Md</u>				





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">71 12067</span>	
V-422 <span style="font-size: 1.2em;">71 12067</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Italo Valsecchi</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12/28/71</span> <span style="float: right;">12 05 P. M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">4012 Hamilton Ave.</span>		A. STATE <span style="font-size: 1.2em;">Md.</span>		B. COUNTY <span style="font-size: 1.2em;">2734</span>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <span style="font-size: 1.2em;">4012 Hamilton Ave.</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10.2. 1920</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">51</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Constructual Eng.</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Federal Govt.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Italy</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Italo Valsecchi, Sr.</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Ramanzina Onbretta</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">219287242</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Catherine Valsecchi</span>	
				ADDRESS <span style="font-size: 1.2em;">Same</span>	
18. <span style="font-size: 1.2em;">I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Squamous Cell Carcinoma Left Lung</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">Oct 29, 1971</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">Co Lung</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">2. 12. 1960</span> to <span style="font-size: 1.2em;">12. 30. 1971</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12. 20. 1971</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Sebastian Russo MD</span>		DEGREE <span style="font-size: 1.2em;">MD</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">12/28/71</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">SEBASTIAN RUSSO</span>		23D. ADDRESS <span style="font-size: 1.2em;">5017 Harford Rd. Baltimore Md</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">12 31 71</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Cedar Hill Cemetery</span>	
				24D. LOCATION <span style="font-size: 1.2em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 30 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Russo, Md.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leonard J. Ruck Inc., Balto. Md 21214</span>	

1942

1. 1. 1942

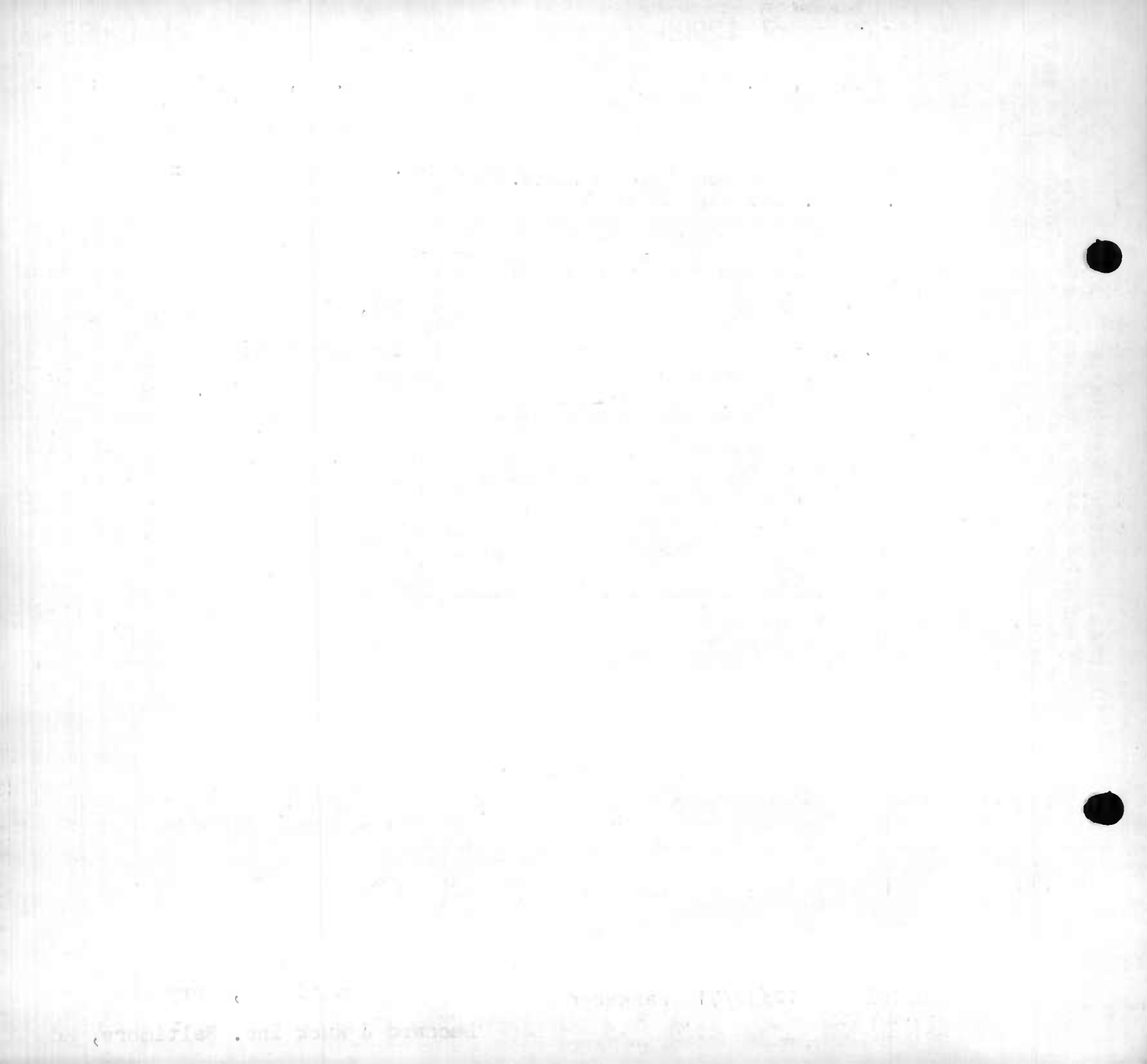
1. 1. 1942

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# FUNERAL DIRECTOR: IMPORTANT


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 12068</span>
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">W-425 71 12068</span>		<b>CERTIFICATE OF DEATH</b>		
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">WILSON, MR. GUY HOMER</span>		<b>2. DATE AND HOUR OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.2em;">Dec. 28, 1971</span> <span style="font-size: 1.2em;">1:25 P.M.</span> </div>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Keswick Home for Incurables Of Balto. City. 700 W. 40th Street 21211</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>A. STATE</b>  <span style="font-size: 1.2em;">MD</span> </div> <div style="width: 50%;"> <b>B. COUNTY</b>  <span style="font-size: 1.2em;">604 Montpelier Street 905</span> </div> </div> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Balto.</span>		
<b>5. SEX</b> <div style="display: flex; justify-content: space-around;"> <span style="font-size: 1.2em;">M</span> <span style="font-size: 1.2em;">W</span> </div>		<b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.2em;">11-18-1889 82</span>		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Sheet Metal worker</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Doe Hill, Virginia</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">John H. Wilson</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Martha Jane Siple</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">??? ???</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">217-14-2229</span>		
<b>17. INFORMANT</b> <span style="font-size: 1.2em;">KESWICK FILES</span>		<b>ADDRESS</b> <span style="font-size: 1.2em;">700 W. 40th Street</span>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">492X I Myocardial Infarction</span>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">Instant</span>		
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <span style="font-size: 1.2em;">(B) Pulmonary Embolism 11 yrs</span> <span style="font-size: 1.2em;">(C) Osteoarthritis 15 yrs</span>				
II				
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">1971</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		
<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">21C. WHERE DID INJURY OCCUR?</span>		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
<b>22. I certify that (I) (this hospital) attended the deceased from 3 Aug 1971 to 28 Dec 1971, that (I) (we) lost saw the deceased alive on 28 Dec 1971 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">[Signature]</span>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">28 Dec 1971</span>		
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">[Signature]</span>		<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">[Address]</span>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">12/30/71</span>		
<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Parkwood</span>		<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">DEC 30 1971</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">[Signature]</span>		
<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Leonard J Ruck Inc. Baltimore, Md</span>		<b>ADDRESS</b>		



# FUNERAL DIRECTOR: IMPORTANT

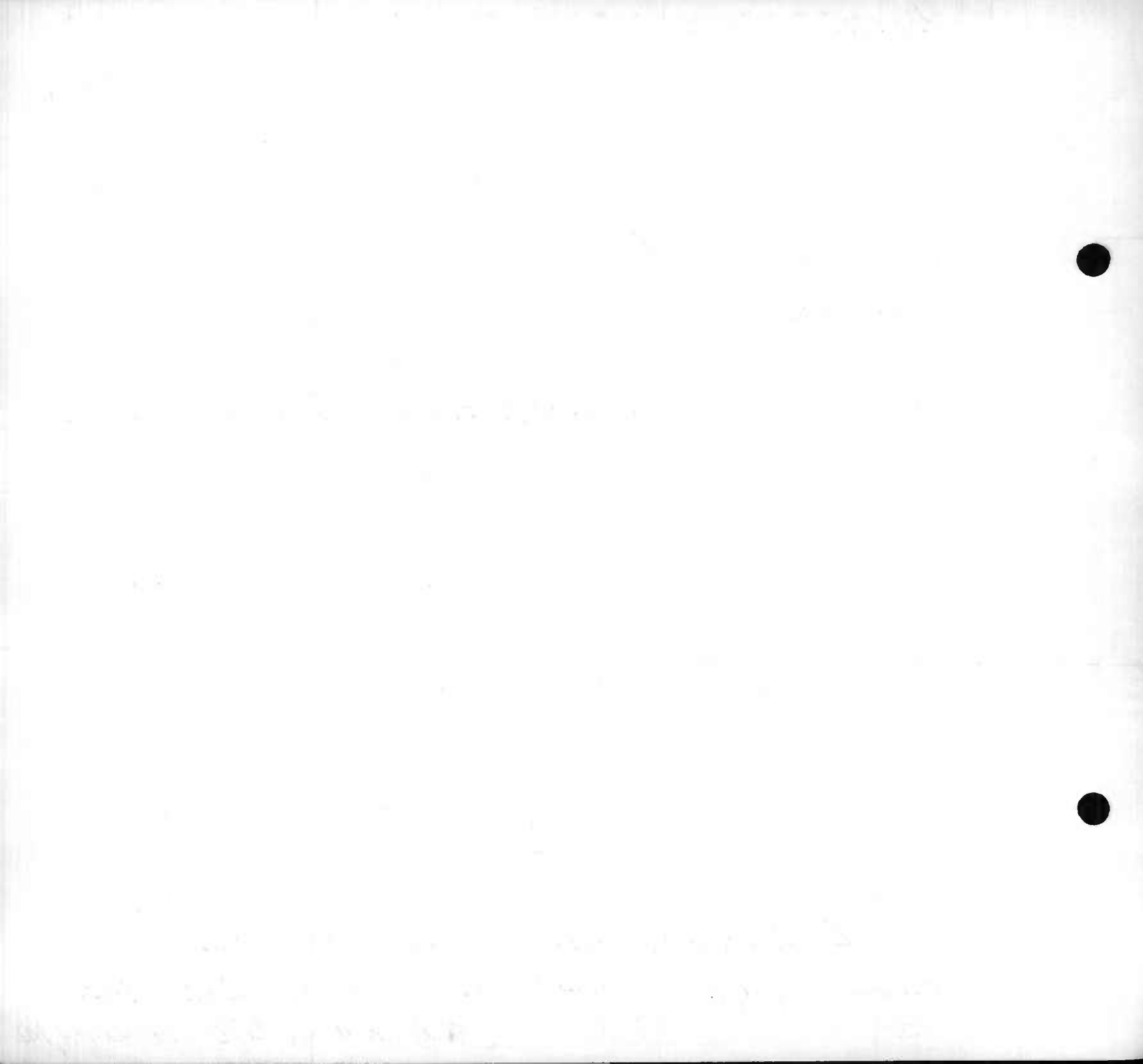
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">71 12069</span>	
T-460 71 12069				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">WILLIAM H. TAYLOR</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">DECEMBER 28, 1971 8:10 A. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.1em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.1em;">2706</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">44</span> <span style="font-size: 1.1em;">UNION MEMORIAL HOSPITAL</span>			C. CITY OR TOWN <span style="font-size: 1.1em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			E. STREET AND NUMBER <span style="font-size: 1.1em;">2930 Glenmore Ave.</span>		
5. SEX <span style="font-size: 1.1em;">Male</span>	6. RACE <span style="font-size: 1.1em;">Cauc.</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.1em;">09-21-01</span>	9. AGE (In years last birthday) <span style="font-size: 1.1em;">70</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Ret. Electrician</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.1em;">Marine</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">MARYLAND</span>
12. CITIZEN OF WHAT COUNTRY <span style="font-size: 1.1em;">USA</span>			13. FATHER'S NAME <span style="font-size: 1.1em;">William ROBERT TAYLOR</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Alice A Phoebus</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">No</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">64-03-3026A</span>			17. INFORMANT <span style="font-size: 1.1em;">Mrs Anna Schemm</span>		
18. CAUSE OF DEATH <span style="font-size: 1.1em;">440.9 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <span style="font-size: 1.1em;">0</span> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  20A. AUTOPSY? (Yes or No)  20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  21D. TIME OF INJURY (Approx.)  21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  21F. HOW DID INJURY OCCUR?  22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">12/26</span> 19 <span style="font-size: 1.1em;">71</span> to <span style="font-size: 1.1em;">12/28</span> 19 <span style="font-size: 1.1em;">71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">12/28</span> 19 <span style="font-size: 1.1em;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED <span style="font-size: 1.1em;">12/28/71</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">CESAR VILLAN</span>			23D. ADDRESS <span style="font-size: 1.1em;">33rd and Calvert St.</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>			24B. DATE <span style="font-size: 1.1em;">12-30-71</span>		
24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.1em;">New Cathedral Cem.</span>			24D. LOCATION <span style="font-size: 1.1em;">Balto. Md.</span>		
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">DEC 30 1971</span>			25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">Robert E. Taylor, M.D.</span>		
25C. FUNERAL DIRECTOR <span style="font-size: 1.1em;">Leonard J. Ruck Inc.</span>			25D. ADDRESS <span style="font-size: 1.1em;">Balto. Md. 21214</span>		

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>71 12070</b>	
P-362 71 12070			
1. NAME OF DECEASED (Type or Print) <b>SARAH ELIZABETH PATTERSON</b>		2. DATE AND HOUR OF DEATH <b>12/23/71 8:17 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MARYLAND HOSPITAL 38</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>DORCHESTER</b> C. CITY OR TOWN <b>CAMBRIDGE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>RT. 1 BOX 147</b>	
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/26/28</b> 9. AGE (in years last birthday) <b>43</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES MARINE</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213 24-1892</b>	
17. INFIRMANT <b>BENJAMIN PATTERSON</b>		ADDRESS <b>CAMB. MD.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  (A) IMMEDIATE CAUSE <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>BREAST CARCINOMA; POSSIBLE CEREBRAL METASTASIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>FEB. 1969</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BREAST CARCINOMA</b>	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>(APPROX.)</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/21/71</b> 19 to <b>12/23/71</b> 19 that (I) (we) last saw the deceased alive on <b>12/23/71</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE <b>I. WEXLER M.D.</b>		23B. DATE SIGNED <b>12/23/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>I. WEXLER M.D.</b>		23D. ADDRESS <b>BALTIMORE, MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12/29/71</b>	24C. NAME OF CEMETERY OR CREMATORY <b>CHRIST ROCK</b>	24D. LOCATION (City, town, or county) (State) <b>ROCK DOR. MD.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>	25B. NAME OF REGISTRAR <b>John E. Jolly, Jr.</b>	25C. FUNERAL DIRECTOR <b>Frederick C. Jolly</b>	ADDRESS <b>CAMBRIDGE, MD.</b>





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">71 12071</span>
M-620 71 12071		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
ARTHUR L MYERS Sr		December 27, 1971 8:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  2804 Beechland Ave.		A. STATE Md. B. COUNTY 2706		
C. CITY OR TOWN		D. INSIDE CITY LIMITS?		
Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER		2804 Beechland Ave.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 1, 1894	77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Retired Self Employed		Ice Co		Maryland
12. CITIZEN OF WHAT COUNTRY?		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Arthur J Myers		?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No		218-32-2768		Mrs Ada V Myers Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Prostate Metastasis Arteriosclerotic Heart Dresser Cougher Fault		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22. I certify that (I) (this hospital) attended the deceased from 12/25/71 to 12/27/71, that (I) (we) last saw the deceased alive on 12/25/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Dr. Donald R. Mintzer		23B. DATE SIGNED 12/27/71		23C. PHYSICIAN'S NAME (Type)
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY
Burial		12/30/71		Moreland Mem Pk
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
DEC 30 1971		Leonard J. Ruck Inc., Balto. Md. 21214		

MEMORANDUM FOR THE DIRECTOR

Re: [illegible]

Date: [illegible]

Subject: [illegible]

1. [illegible]

Very truly yours,  
[illegible]

Enclosure  
[illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-450 71 12072				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12072	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>ADAM M. KLEIN</b>		2. DATE AND HOUR OF DEATH <b>12/27/71 12 20 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>CITY</b>		C. CITY OR TOWN <b>CITY</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland General Hospital</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>4902 LA SALLE AVE 21206</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/6/93</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Plumber</b>			10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Nicholas Klein</b>				14. MOTHER'S MAIDEN NAME <b>Magdaline ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>218-07-1965</b>	17. INFORMANT <b>Miss Dorothea Klein</b>		ADDRESS <b>(Same)</b>		
18. I <b>185X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Ventricular Fib</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Metastasis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Adenocarcinoma Prostate</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>Dec 27</b> 19 <b>71</b> to <b>Dec 27</b> 19 <b>71</b> that (1) (we) last saw the deceased alive on <b>Dec 27</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>George C. Samaras</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/27/71</b>	
23C. PHYSICIAN'S NAME (Typed) <b>George C. Samaras</b>		23D. ADDRESS <b>Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/30/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>		25B. NAME OF REGISTRAR <b>Robert J. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard O. Buck, Inc.</b>		ADDRESS <b>Balto. Md. 21214</b>	



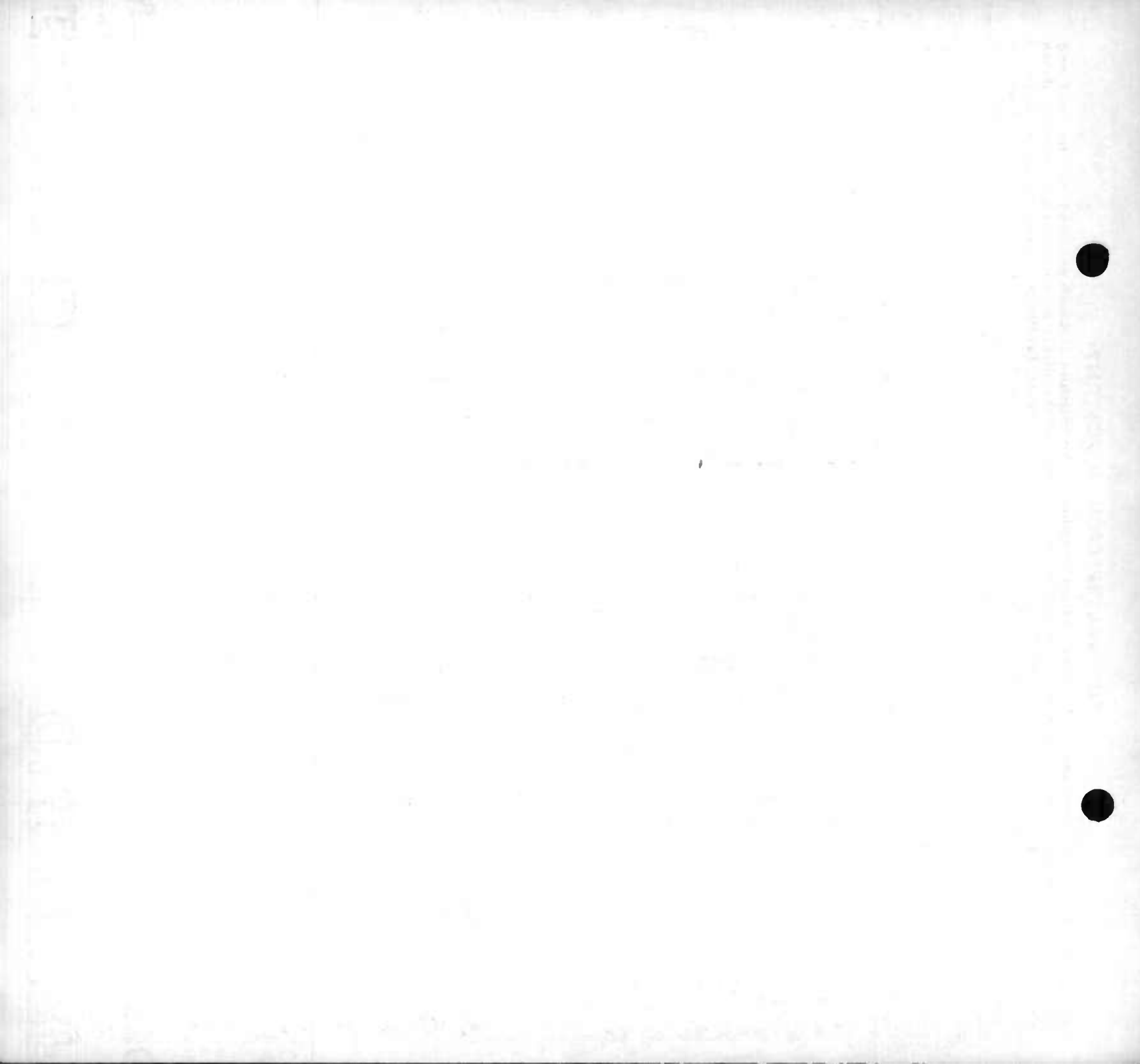
1. NAME OF DECEASED (Type or Print) Wilfore Feenell		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 24 71 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 24 71 9:35 a. M.	
6. SEX male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 30		E. STREET AND NUMBER 1639 Thomas Avenue	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 24 2415 North Avenue 1503	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12 24 71 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Subject shot during altercation		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.	
DATE SIGNED 12/25/71		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-29-71	
24C. NAME of CEMETERY or CREMATORY MOUNT AUBURN (EM)		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR Rose E. Jones, R.A.	
25C. FUNERAL DIRECTOR HOWARD CO. FUN. HOME		ADDRESS PIKE CHURCH	

4 2848

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-230 71 12074		BALTIMORE CITY HEALTH DEPARTMENT		71 12074	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DAVID A. WISCOTT</b>		2. DATE AND HOUR OF DEATH <b>12-28-71 7 10 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Church Home and Hospital</b> <b>100 N Broadway St</b> <b>Balt. MD 21231</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore County</b> C. CITY OR TOWN <b>Baltimore County</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>7305 Hughes</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>03-07-93</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Tr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Moulder</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Wiscott</b>		14. MOTHER'S MAIDEN NAME <b>Georgetti Doffer</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>A. Samuel Mbur</b> ADDRESS <b>Church Home Hosp</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Cancer of Prostate</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Some years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>C. &amp; P. v. P.</b>			
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>None</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <b>None</b>		22. I certify that (I) (this hospital) attended the deceased from <b>12-15-1971</b> to <b>12-28-1971</b> that (I) (we) last saw the deceased alive on <b>12-28-1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Gemma P. Indolos M.D.</b>		23B. DATE SIGNED <b>Dec. 28, 1971</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>GEMMA P. INDOLOS M.D.</b>		23D. ADDRESS <b>Church Home &amp; Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>DEC 31, 1971</b>		24C. NAME OF CEMETERY or CREMATORY <b>ST. JAMES</b>	
24D. LOCATION (City, town, or county) (State) <b>NEW WINDSOR, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>			
25B. NAME OF REGISTRAR <b>Robert J. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>HOWARD COUNTY ADDRESS</b>			

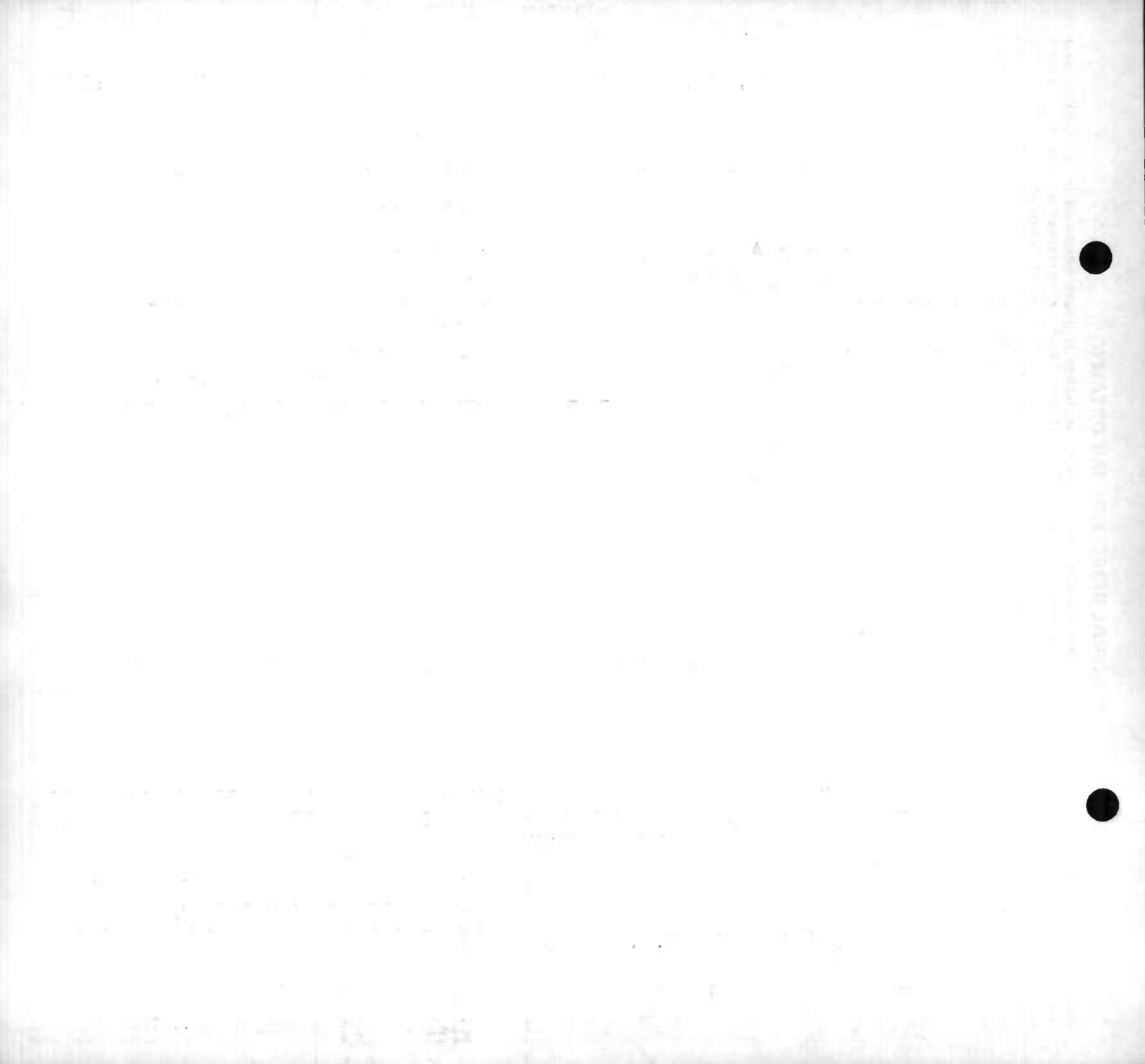




# FUNERAL DIRECTOR: IMPORTANT

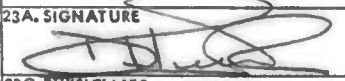
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>H-620</span> <span>71 12075</span> </div>		BALTIMORE CITY HEALTH DEPT. <b>CERTIFICATE OF DEATH</b>		REG. NO. <span style="font-size: 1.2em;">71 12075</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">HIRSCH, HELENE MARIE</span>			2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> <span>DECEMBER 27 1971</span> <span>7:30P M.</span> </div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <div style="display: flex; justify-content: space-between;"> <div>           FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.2em;">40</span>            ST AGNES HOSPITAL         </div> <div>           (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)         </div> </div>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <div style="display: flex; justify-content: space-between;"> <div>           A. STATE  <span style="font-size: 1.1em;">MARYLAND</span> </div> <div>           B. COUNTY  <span style="font-size: 1.5em;">2854</span> </div> </div>		
5. SEX <span style="font-size: 1.1em;">FEMALE</span>			6. RACE <span style="font-size: 1.1em;">CAUCASIAN</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <span style="font-size: 1.1em;">02 23 91</span>		9. AGE (In years last birthday) <span style="font-size: 1.1em;">80</span>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">HOUSEWIFE</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">GERMANY</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">U S A</span>			13. FATHER'S NAME <span style="font-size: 1.1em;">OTTO UHLICH</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">MARIE TURK</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">215-09-9689D</span>			17. INFORMANT <div style="display: flex; justify-content: space-between;"> <span>BALTIMORE MD 21229</span> <span>ADDRESS</span> </div> <span style="font-size: 1.1em;">ST AGNES RECORDS WILKENS &amp; CATON AVES</span>		
18. <span style="font-size: 1.2em;">15-3-31</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.1em;">Pneumonia @ Colon</span>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.1em;">Loss of myocardial color</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.1em;">6 months to liver</span>		
(C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.1em;">10 days</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.1em;">Cholelithiasis</span>					
19A. DATE OF OPERATION <span style="font-size: 1.1em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.1em;">YES</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <span style="font-size: 1.1em;">DECEMBER 06</span> <span style="font-size: 1.1em;">19 71</span> to <span style="font-size: 1.1em;">DECEMBER 27</span> <span style="font-size: 1.1em;">19 71</span> that (X) (we) last saw the deceased alive on <span style="font-size: 1.1em;">DECEMBER 27</span> <span style="font-size: 1.1em;">19 71</span> and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Jose Apter M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.1em;">12 28 71</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">JOSE APTER M.D.</span>				23D. ADDRESS <span style="font-size: 1.1em;">ST AGNES HOSPITAL WILKENS &amp; CATON AVES BALTO MD 21229</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">12/30/71</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.1em;">Loudon Park</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore, Maryland</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 30 1971</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">E. J. ...</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.1em;">Witzke, 71630 Edmondson Ave., 21228</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 12076</u>	
BIRTH NO. <u>D-125 71 12076</u>				1. NAME OF DECEASED (Type or Print) <u>DE VAUGHN, GEORGE, SR</u>		2. DATE AND HOUR OF DEATH <u>DECEMBER 28, 1971</u> <u>11:20A.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST. AGNES HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>CATONSVILLE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>31 EDMONDSON RIDGE RD 21228</u>			
5. SEX <u>MALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07/11/05</u>		9. AGE (In years last birthday) <u>66</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SALES BOOK CO</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>ELIZABETH MC HARDY DE VAUGHN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>215-07-1197</u>		17. INFORMANT ADDRESS <u>ST. AGNES HOSPITAL RECORDS</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>185-X I Carcinoma of prostate gland</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH <u>Carcinoma of prostate gland</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 28</u> <u>19 71</u> to <u>DECEMBER 28</u> <u>19 71</u> that (I) (we) last saw the deceased alive on <u>DECEMBER 28</u> <u>19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				DEGREE		23B. DATE SIGNED <u>12-28-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Daniel Huerta</u>				23D. ADDRESS <u>BALTIMORE, MARYLAND 21229</u> <u>ST. AGNES HOSPITAL; CATON &amp; WILKENS AVES</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/31/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REV'D BY HEALTH DEPT. <u>DEC 30 1971</u>				25B. NAME OF REGISTRAR <u>Robert E. Vaughn, R.D.O.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Witzke, 71630 Edmondson Avenue 21228</u>	

10/10/1964

21

Examination of prostate gland

42

42

15-58-31

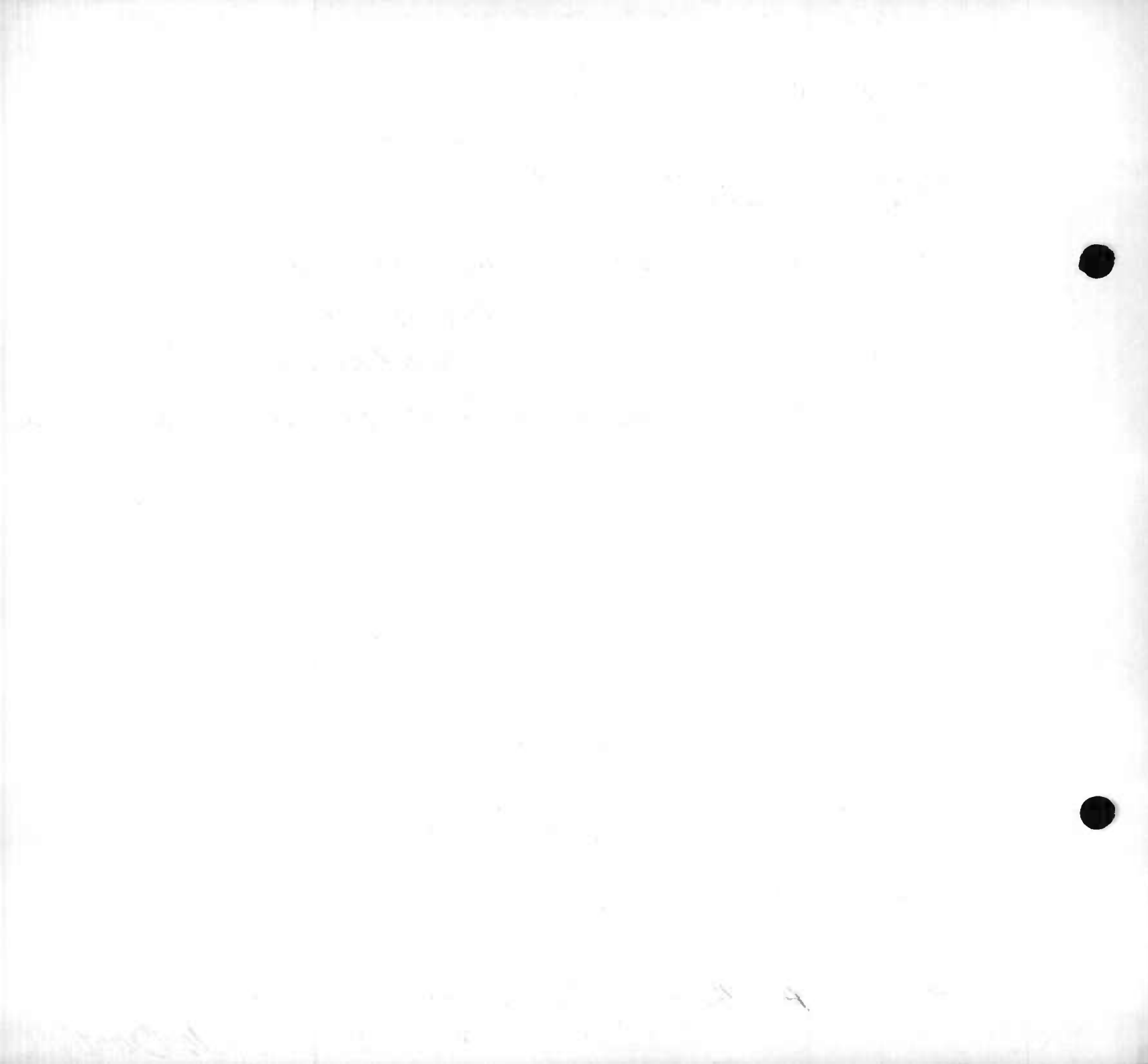


Daniel H. Hester

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				71 12077 REG. NO.	
BIRTH NO. <u>S-512 71 12077</u>		1. NAME OF DECEASED (Type as Printed) <u>SIMPSON, Gertrude</u>			
2. DATE AND HOUR OF DEATH <u>12/26/71</u> <u>10:40 P.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>DuKeland Nursing Home</u> <u>1501 N. DuKeland</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>605</u>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>DuKeland Nursing Home</u> <u>1501 N. DuKeland</u>			
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/25/81</u>	9. AGE (in years last birthday) <u>90</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217668300</u>		17. INFORMANT <u>Joyce Russell</u> ADDRESS <u>3006 Calver Ave</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>ASCVD</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CH. BRAIN SYNDROME</u>		CAUSE OF DEATH <u>ASCVD</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CH. BRAIN SYNDROME</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>12/8/71</u> to <u>12/26/71</u> that (1) (we) last saw the deceased alive on <u>12/26/71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Phillip E. B. Byrd, Jr.</u>		23B. DATE SIGNED <u>12/26/71</u>		23C. PHYSICIAN'S NAME (Type) <u>PHILLIP E. B. BYRD, Jr.</u>	
23D. ADDRESS <u>2707 HANSON AVE, BALTO. MD</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>12-26</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Catholic Ch</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1971</u>		25B. NAME OF REGISTRAR <u>John A. ...</u>		25C. FUNERAL DIRECTOR <u>Phillip E. B. Byrd, Jr.</u>	
25D. ADDRESS <u>...</u>		25E. ADDRESS <u>...</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 12078</u>	
BIRTH NO. <u>C-350 71 12078</u>		1. NAME OF DECEASED (Type or Print) <u>HELEN B. CHEATHAM</u>		2. DATE AND HOUR OF DEATH <u>12-27-71</u> <u>9:18</u> <u>A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1002</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>715 N. Central Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/26/05</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Helen J. Cheatham</u> ADDRESS <u>Same</u>	
18. <u>174X 1250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Prob. sepsis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metastatic breast cancer</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Prob. sepsis</u> (B) <u>Metastatic breast cancer</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~ 10 days</u> <u>6 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>HASCVD, DIABETES</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>N/A</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>N/A</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>N/A</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>N/A</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>N/A</u>		21F. HOW DID INJURY OCCUR? <u>N/A</u>	
22. I certify that (1) <u>(at hospital)</u> attended the deceased from <u>12-24</u> 19 <u>71</u> to <u>12-27</u> 19 <u>71</u> that (1) <u>(we)</u> last saw the deceased alive on <u>12-27</u> 19 <u>71</u> and that in (my) <u>(over)</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>(we)</u> <u>(did)</u> view the body after death.					
23A. SIGNATURE <u>Steven E. Rubin MD</u>		23B. DATE SIGNED <u>12-27-71</u>		23C. PHYSICIAN'S NAME (Type) <u>STEVEN E. RUBIN MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-31-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>McCahey Cmt</u>	
24D. LOCATION (City, town, or county) (State) <u>W.A. County Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert J. ...</u>	
25C. FUNERAL DIRECTOR <u>Robert J. ...</u>		25D. ADDRESS <u>1000 ...</u>			

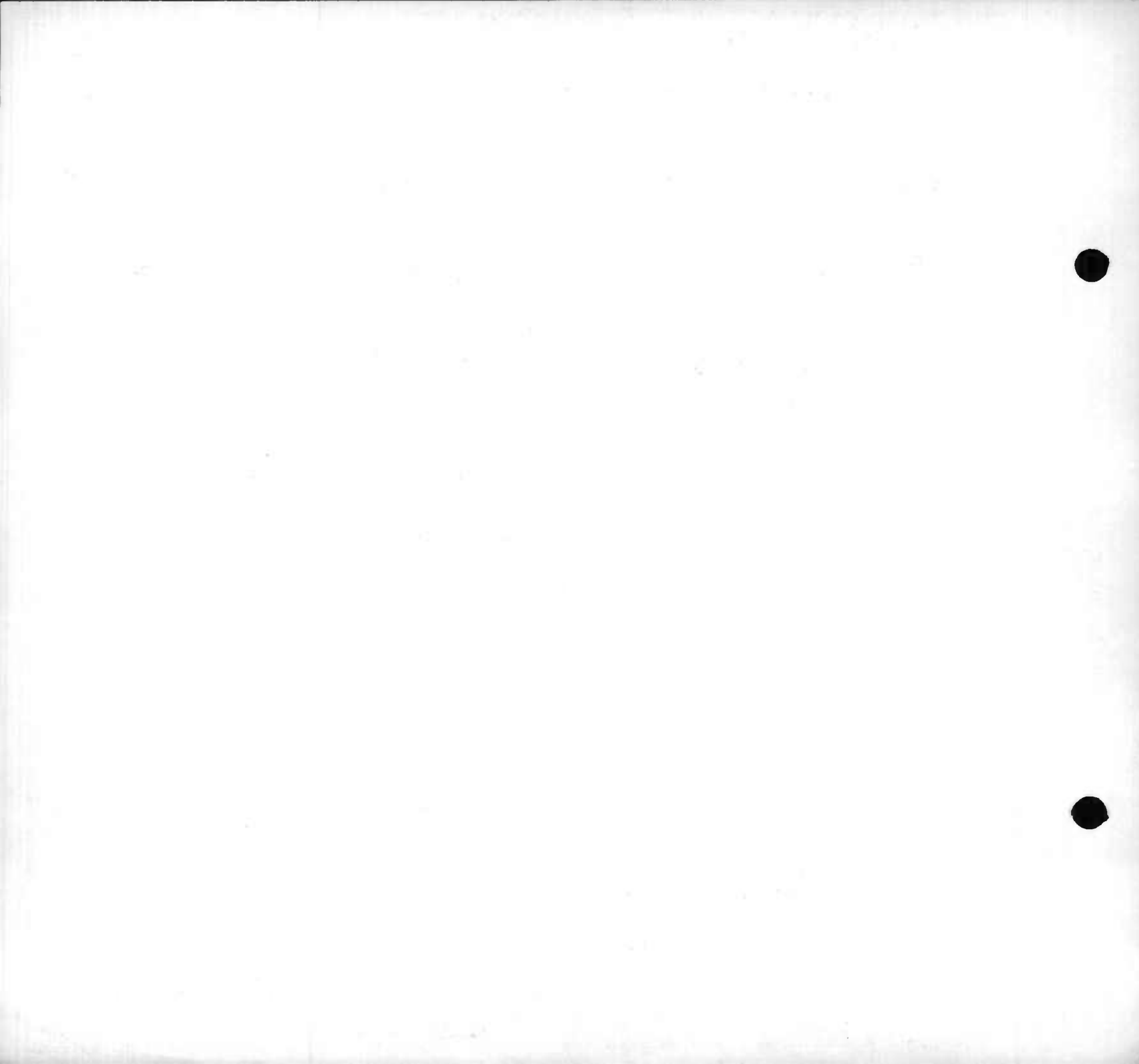




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

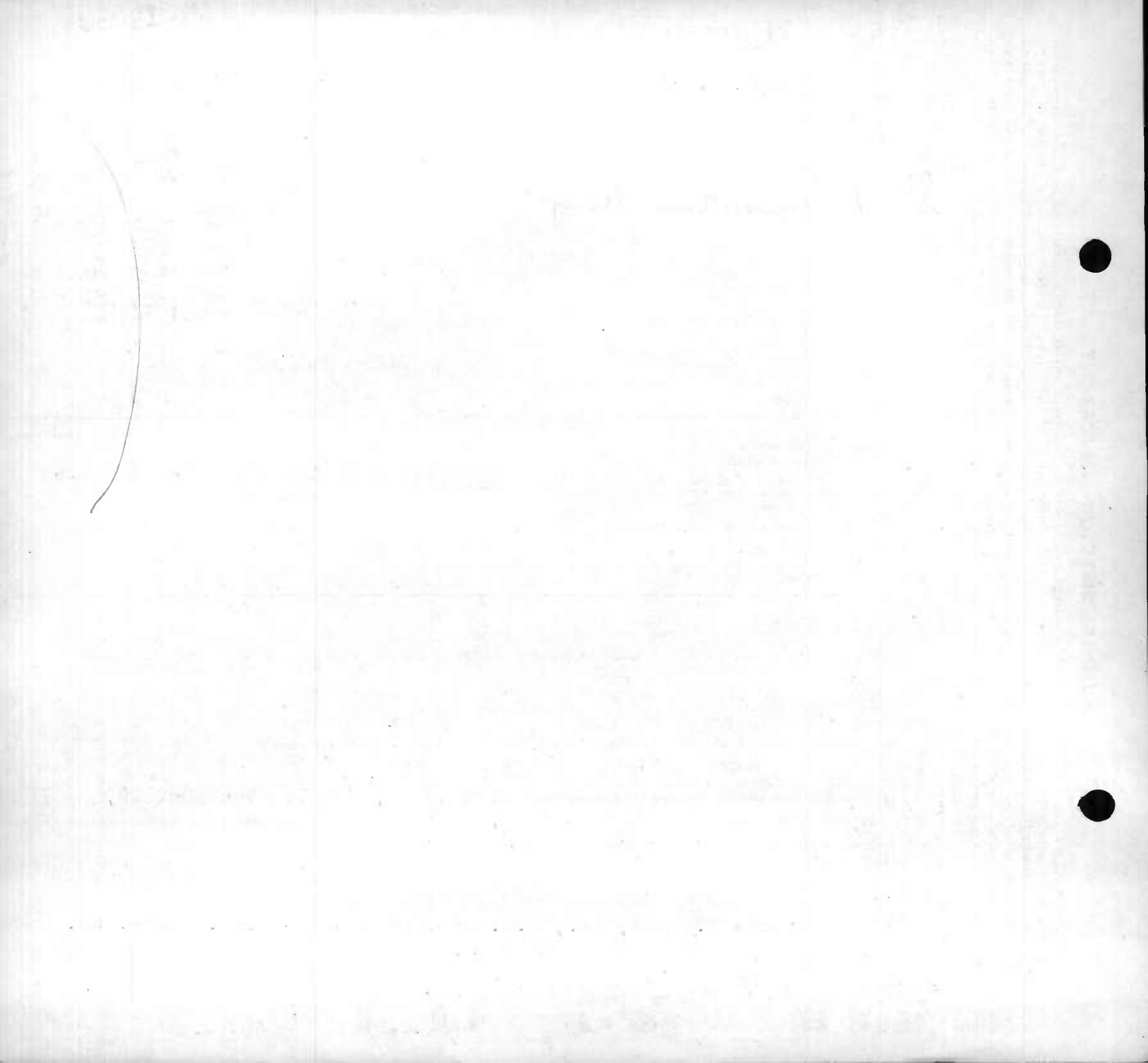
Baltimore City Health Department				REG. NO. 71 12079	
BIRTH NO. 8-620-28371 12079		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BROOKS, BABY GIRL</b>		2. DATE AND HOUR OF DEATH <b>12/28/71 9:10 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME AND HOSPITAL</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>35</b>		A. STATE <b>Maryland</b> B. COUNTY <b>5200</b>	
5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>12/27/71</b> 9. AGE (In years last birthday) <b>2</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
13. FATHER'S NAME <b>William Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Betty Johnson</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>William R. Brooks</b> ADDRESS <b>Same</b>	
18. <b>778.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Immaturity (25 weeks)</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Cardiorespiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Marked asites</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/27</b> 19 <b>71</b> to <b>12/28</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>19</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Johnny Eufemio M.D.</b>		23B. DATE SIGNED <b>12/28/71</b>		23C. PHYSICIAN'S NAME (Type) <b>JOHNNY EUFEMIO M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12-29-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cmt</b>	
24D. LOCATION (City, town, or county) (State) <b>Ad County Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Wilson</b>	
25C. FUNERAL DIRECTOR <b>Robert E. Wilson</b>		ADDRESS <b>1000 Community</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

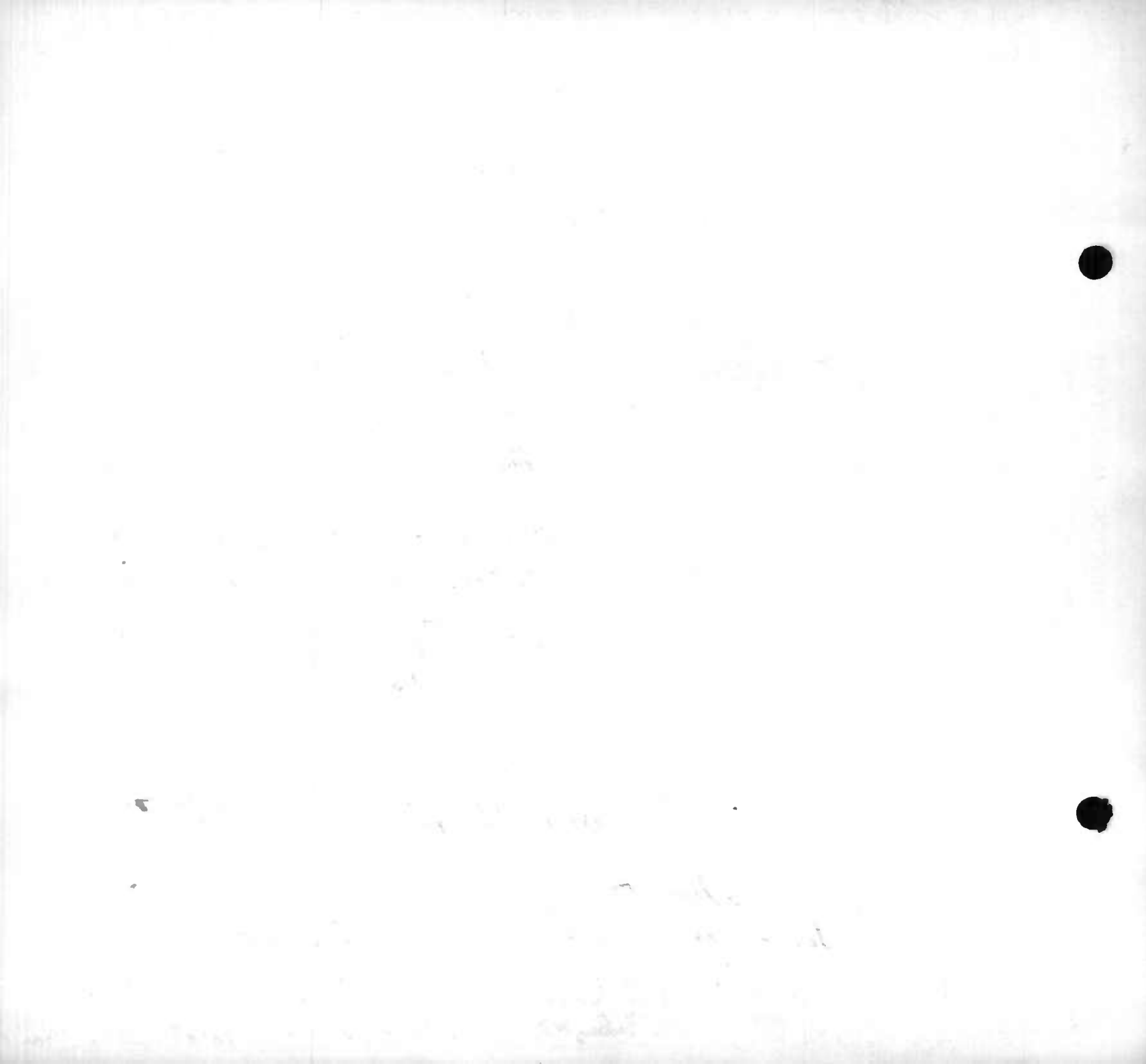
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 12080</b>
<b>B-400</b> <b>71 12080</b> BIRTH NO.		2. DATE AND HOUR OF DEATH <b>December 29, 1971 6:15 AM</b>		
1. NAME OF DECEASED (Type or Print) <b>Annie E. Blue</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Hood Sansation Hoop</b>		
5. SEX <b>Female</b>		6. RACE <b>Black</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		8. DATE OF BIRTH <b>March 23 1924</b>
13. FATHER'S NAME <b>Elizabeth McDonald</b>		14. MOTHER'S MAIDEN NAME <b>Emma Gregg</b>		9. AGE (In years last birthday) <b>45</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>70</b>		17. INFORMANT <b>Carol P Blue</b>
18. <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Colonic Carcinoma</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Metastatic Colonic Carcinoma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>XXX</b>		20A. AUTOPSY? (Yes or No) <b>XXX</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>XXX</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>XXX</b>
21D. TIME OF INJURY (APPROX.) <b>XXX</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>XXX</b>
22. I certify that <b>N</b> (this hospital) attended the deceased from <b>December 28, 1971</b> to <b>December 29, 1971</b> , that <b>(I)</b> last saw the deceased alive on <b>December 28, 1971</b> and that in (my) <b>(X)</b> opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> <b>(X)</b> (did) <b>(X)</b> view the body after death.				
23A. SIGNATURE <b>George H. Sack, Jr.</b>		23B. DATE SIGNED <b>12/29/71</b>		23C. PHYSICIAN'S NAME (Type) <b>George H. Sack, Jr., M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-4-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>mt Auburn Cmt</b>
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>		
25B. NAME OF REGISTRAR <b>John E. Sack, Jr.</b>		25C. FUNERAL DIRECTOR <b>W. Wilson</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>48112081</u>
BIRTH NO. <u>71 12081</u>		2. DATE AND HOUR OF DEATH <u>12/28/71</u>		
1. NAME OF DECEASED (Type or Print) <u>Hatchett William</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Harbor View Nursing Center</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
4. SEX <u>M</u>	5. RACE <u>N</u>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <u>9/25/98</u>	8. AGE (in years last birthday) <u>73</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>CHAUFFEUR</u>		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME <u>Henry Hatchett</u>		14. MOTHER'S MAIDEN NAME <u>Irene Jackson - Virginia</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-09-9528A</u>		17. INFORMANT ADDRESS
18. <u>412-4</u> I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Broncho Pneumonia - Terminal</u>		<u>4 days</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>A-S-C-V. Disease</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>?</u>
		(C) <u>C.V.A. Hemiparesis</u>		<u>Nov 1969</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Smoking</u>		<u>?</u>
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>11/24/69</u> 19 <u>71</u> to <u>12/28/71</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>12/17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Joseph S. Blum</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12/28/71</u>
23C. PHYSICIAN'S NAME (Type) <u>Joseph S. Blum, MD</u>		23D. ADDRESS <u>1115 N. CALVERT ST</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12-30-71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>MT. Calvary</u>	24D. LOCATION (City, town, or county) (State) <u>Brooklyn, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>	25C. FUNERAL DIRECTOR <u>Edith M. Taylor</u> ADDRESS <u>1008 Brantley Ave.</u>		



S. 432  
S-400  
S-420

71 12082

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12082

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MICHAEL SCHULTZ - SZULC.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		REG. NO.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month <b>December</b> Day <b>28</b> Year <b>1971</b>		Hour <b>3:40 P.</b>			
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>July 6, 1922</b>		10. AGE (In years last birthday) <b>49</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank B. Schultz-Szulo.</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Die-Setter</b>		15. MOTHER'S MAIDEN NAME <b>Mary A. Winiecki</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W. II</b>		17. SOCIAL SECURITY NO. <b>216-12-7456</b>		18. INFORMANT <b>Frank T. Schultz</b>		3504 O'Donnell St. Balto., 21224, Md.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute hemorrhagic pancreatitis</b> <b>Arteriosclerotic Heart Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20A. DATE OF OPERATION <b>12-31-71</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/29/71</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-31-71</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>6015 Boston Ave., Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles S. Geiler</b>		ADDRESS <b>901 S. Conkling St. Balto., 21224, Md.</b>	

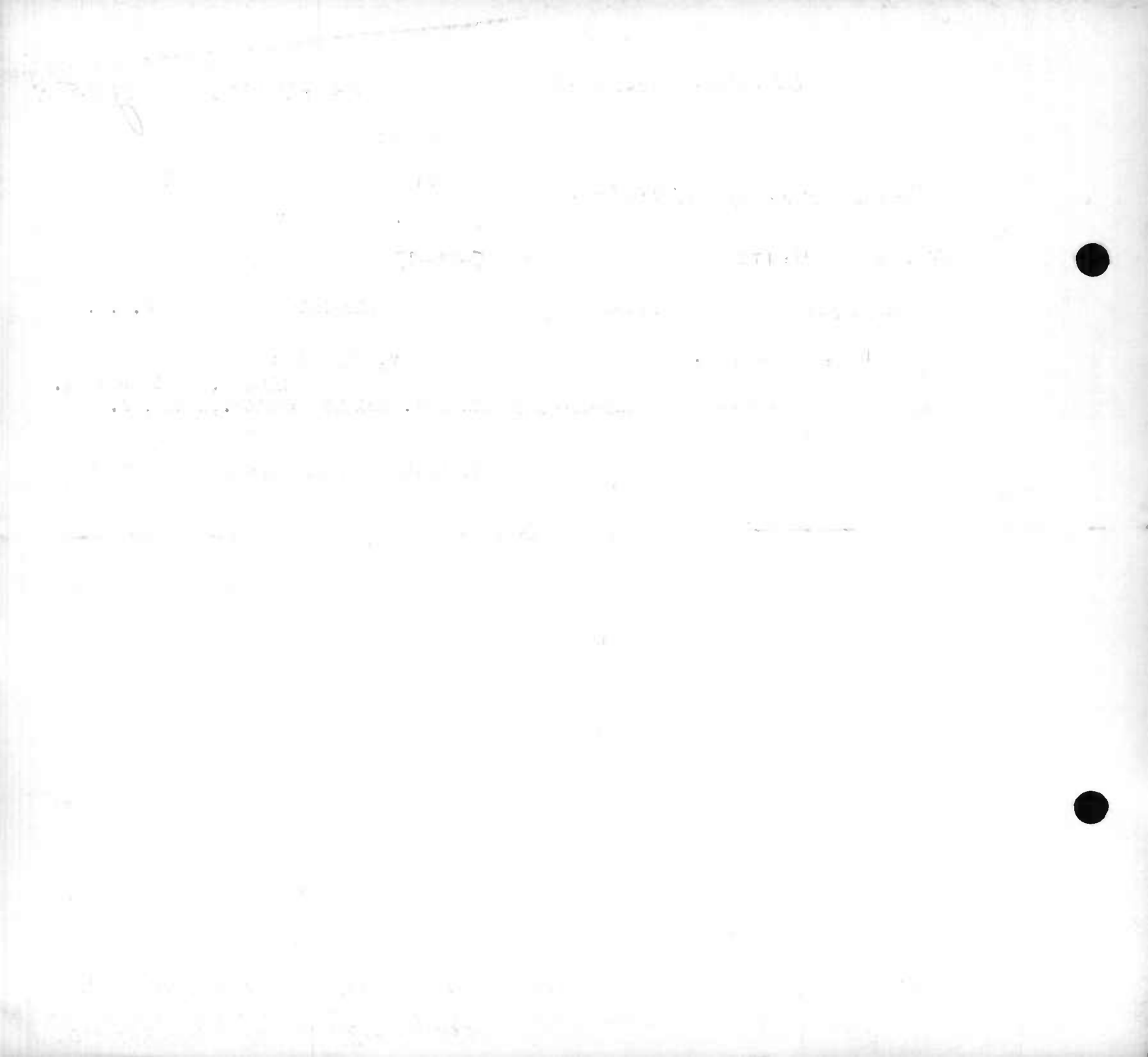
2-16-1972 - Letter from - Office of the Chief Medical Examiner  
Ronald N. Kornblum, M.D.  
Assistant Medical Examiner



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

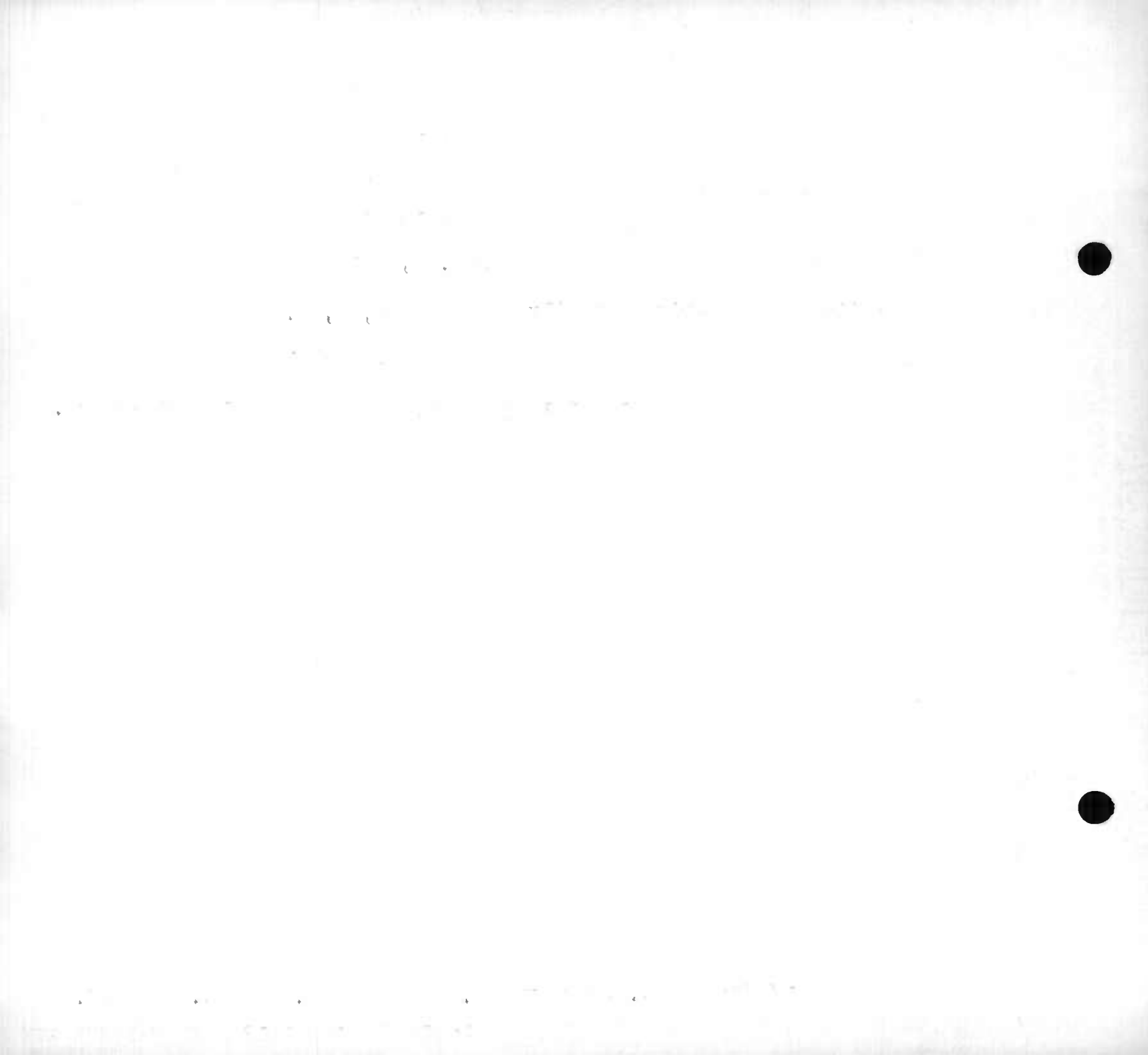
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12083</u>	
BIRTH NO. <u>71 12083</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>WILLIAM T. GALLIER</u>		2. DATE AND HOUR OF DEATH <u>12-27-71</u> <u>5:15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>203</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>728 S. BROADWAY</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-14-33</u>	9. AGE (in years last birthday) <u>58</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GALLIER, THOMAS W.</u>			
14. MOTHER'S MAIDEN NAME <u>DOOLEY, FLORENCE</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>225-03-6363</u>		17. INFORMANT <u>Ellen M. Wright</u> <u>2302 E. Baltimore St. Balto., 21224, Md.</u>			
18. <u>577.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Probable Heart Attack</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>GI bleeding</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>1 week</u>			
(C) <u>Chronic Alcoholism + Post-Hypertensive</u>		<u>10 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>12-27</u> 19 <u>71</u> to <u>12-27</u> 19 <u>71</u> that (2) (we) last saw the deceased alive on <u>12-27</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Neil R Miller, MD</u>				23B. DATE SIGNED <u>12-27-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>NEIL R MILLER, MD</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-29-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>7225 EASTERN BLVD. BA. CO., MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Charles J. Gailer</u> <u>6224 EASTERN AVE. BALTO., 21224, MD.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

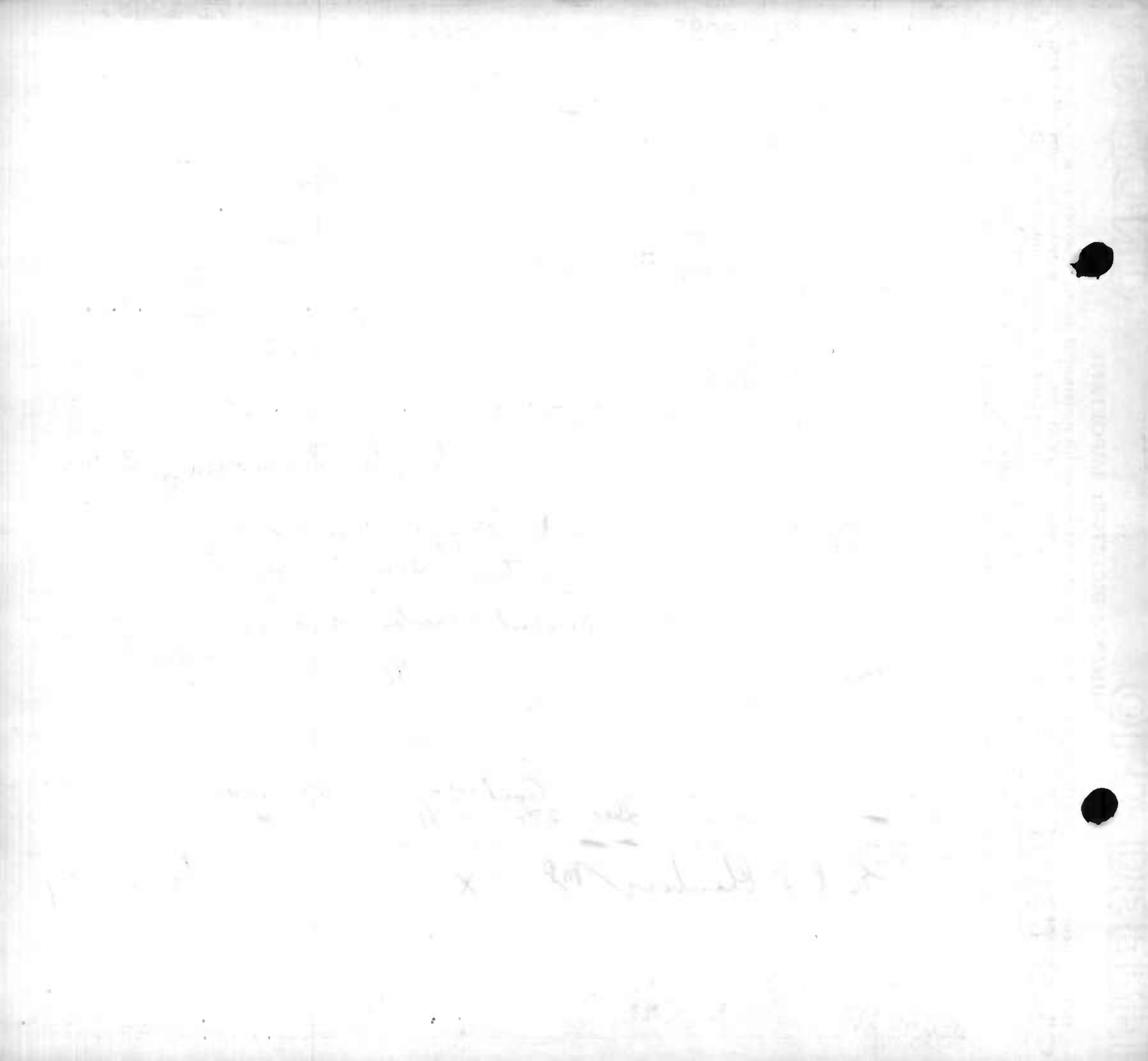
<div style="font-size: 2em; font-weight: bold;">R-223</div> <div style="font-size: 1.5em; font-weight: bold;">71 12084</div>		<div style="font-weight: bold;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-weight: bold;">CERTIFICATE OF DEATH</div>		<div style="font-weight: bold;">REG. NO. 71 12084</div>	
<div style="font-weight: bold;">1. NAME OF DECEASED</div> <div style="font-weight: bold;">(Type or Print)</div> <div style="font-size: 1.5em; font-weight: bold;">REGISTER, IOLA</div>		<div style="font-weight: bold;">2. DATE AND HOUR OF DEATH</div> <div style="font-size: 1.2em;">12-28-71 3:40 p.m.</div>			
<div style="font-weight: bold;">3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</div> <div style="font-weight: bold;">FULL NAME OF HOSPITAL OR INSTITUTION</div> <div style="font-size: 1.5em; font-weight: bold;">42 SINAI HOSPITAL</div>		<div style="font-weight: bold;">4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)</div> <div style="font-weight: bold;">A. STATE</div> <div style="font-weight: bold;">MARYLAND</div> <div style="font-weight: bold;">B. COUNTY</div> <div style="font-size: 2em; font-weight: bold;">2717</div> <div style="font-weight: bold;">C. CITY OR TOWN</div> <div style="font-weight: bold;">BALTIMORE</div> <div style="font-weight: bold;">D. INSIDE CITY LIMITS?</div> <div style="font-weight: bold;">YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> <div style="font-weight: bold;">E. STREET AND NUMBER</div> <div style="font-size: 1.2em; font-weight: bold;">4916 PALMER AVENUE</div>			
<div style="font-weight: bold;">5. SEX</div> <div style="font-weight: bold;">F</div>	<div style="font-weight: bold;">6. RACE</div> <div style="font-weight: bold;">NEGRO</div>	<div style="font-weight: bold;">7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div style="font-weight: bold;">WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div style="font-weight: bold;">8. DATE OF BIRTH</div> <div style="font-size: 1.2em; font-weight: bold;">AUG. 8, 1922</div>	<div style="font-weight: bold;">9. AGE (in years last birthday)</div> <div style="font-size: 1.2em; font-weight: bold;">49</div>
<div style="font-weight: bold;">10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div style="font-weight: bold;">Domestic</div>		<div style="font-weight: bold;">10B. KIND OF BUSINESS OR INDUSTRY</div> <div style="font-weight: bold;">Private Family</div>		<div style="font-weight: bold;">11. BIRTHPLACE (State or foreign country)</div> <div style="font-weight: bold;">FORRESTON, S. C.</div>	
<div style="font-weight: bold;">12. CITIZEN OF WHAT COUNTRY?</div> <div style="font-weight: bold;">USA</div>		<div style="font-weight: bold;">13. FATHER'S NAME</div> <div style="font-weight: bold;">JBE CARTER</div>			
<div style="font-weight: bold;">14. MOTHER'S MAIDEN NAME</div> <div style="font-weight: bold;">CARRIE CANTY</div>		<div style="font-weight: bold;">15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div style="font-weight: bold;">NO</div>			
<div style="font-weight: bold;">16. SOCIAL SECURITY NO.</div> <div style="font-size: 1.2em; font-weight: bold;">215 22 1203</div>		<div style="font-weight: bold;">17. INFORMANT</div> <div style="font-weight: bold;">Herbert Regester 4916 Palmer Ave.</div>			
<div style="font-weight: bold;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div style="font-size: 1.5em; font-weight: bold;">430.0 I</div> <div style="font-size: 0.8em;">(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</div>		<div style="font-weight: bold;">CAUSE OF DEATH</div> <div style="font-weight: bold;">(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</div> <div style="font-size: 1.2em; font-weight: bold;">Subarachnoid hemorrhage</div> <div style="font-weight: bold;">(B) DUE TO, OR AS A CONSEQUENCE OF:</div> <div style="font-size: 1.2em; font-weight: bold;">Hypertension</div> <div style="font-weight: bold;">(C) _____</div>			
<div style="font-weight: bold;">19. ANTECEDENT CAUSES</div> <div style="font-size: 0.8em;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div>		<div style="font-weight: bold;">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div style="font-size: 1.5em; font-weight: bold;">4 d</div>			
<div style="font-weight: bold;">II</div> <div style="font-weight: bold;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</div>					
<div style="font-weight: bold;">19A. DATE OF OPERATION</div> <div style="font-size: 1.2em; font-weight: bold;">0</div>		<div style="font-weight: bold;">19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> <div style="font-size: 1.2em; font-weight: bold;">none</div>		<div style="font-weight: bold;">20A. AUTOPSY? (Yes or No)</div> <div style="font-weight: bold;">NO</div>	
<div style="font-weight: bold;">21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</div> <div style="font-weight: bold;">21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div>		<div style="font-weight: bold;">21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div> <div style="font-weight: bold;">21D. TIME OF INJURY (Approx.)</div> <div style="font-weight: bold;">21E. INJURY OCCURRED</div> <div style="font-weight: bold;">While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div>			
<div style="font-weight: bold;">21F. HOW DID INJURY OCCUR?</div>		<div style="font-weight: bold;">22. I certify that (I) (this hospital) attended the deceased from</div> <div style="font-size: 1.2em; font-weight: bold;">DEC 25 1971 to DEC 28 1971</div> <div style="font-weight: bold;">that (I) (we) last saw the deceased alive on</div> <div style="font-size: 1.2em; font-weight: bold;">DEC 28 1971</div> <div style="font-weight: bold;">and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div>			
<div style="font-weight: bold;">23A. SIGNATURE</div> <div style="font-size: 1.2em; font-weight: bold;">Boris Boonsue</div>		<div style="font-weight: bold;">23B. DATE SIGNED</div> <div style="font-size: 1.2em; font-weight: bold;">12-28-71</div>		<div style="font-weight: bold;">23C. PHYSICIAN'S NAME (Type)</div> <div style="font-size: 1.2em; font-weight: bold;">BRISOOK BOONSUE</div>	
<div style="font-weight: bold;">24A. BURIAL CREMATION, REMOVAL (Specify)</div> <div style="font-weight: bold;">BURIAL</div>		<div style="font-weight: bold;">24B. DATE</div> <div style="font-size: 1.2em; font-weight: bold;">1/3/72</div>		<div style="font-weight: bold;">24C. NAME OF CEMETERY OR CREMATORY</div> <div style="font-weight: bold;">MT. CALVARY CEM.</div>	
<div style="font-weight: bold;">24D. LOCATION (City, town, or county) (State)</div> <div style="font-weight: bold;">BALTO. (AA Co.) MD.</div>		<div style="font-weight: bold;">25A. DATE RECD BY HEALTH DEPT.</div> <div style="font-size: 1.2em; font-weight: bold;">DEC 30 1971</div>			
<div style="font-weight: bold;">25B. NAME OF REGISTRAR</div> <div style="font-size: 1.2em; font-weight: bold;">LEWIS T GWYNN</div>		<div style="font-weight: bold;">25C. FUNERAL DIRECTOR</div> <div style="font-size: 1.2em; font-weight: bold;">4517 PARK HEIGHTS AVE</div>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

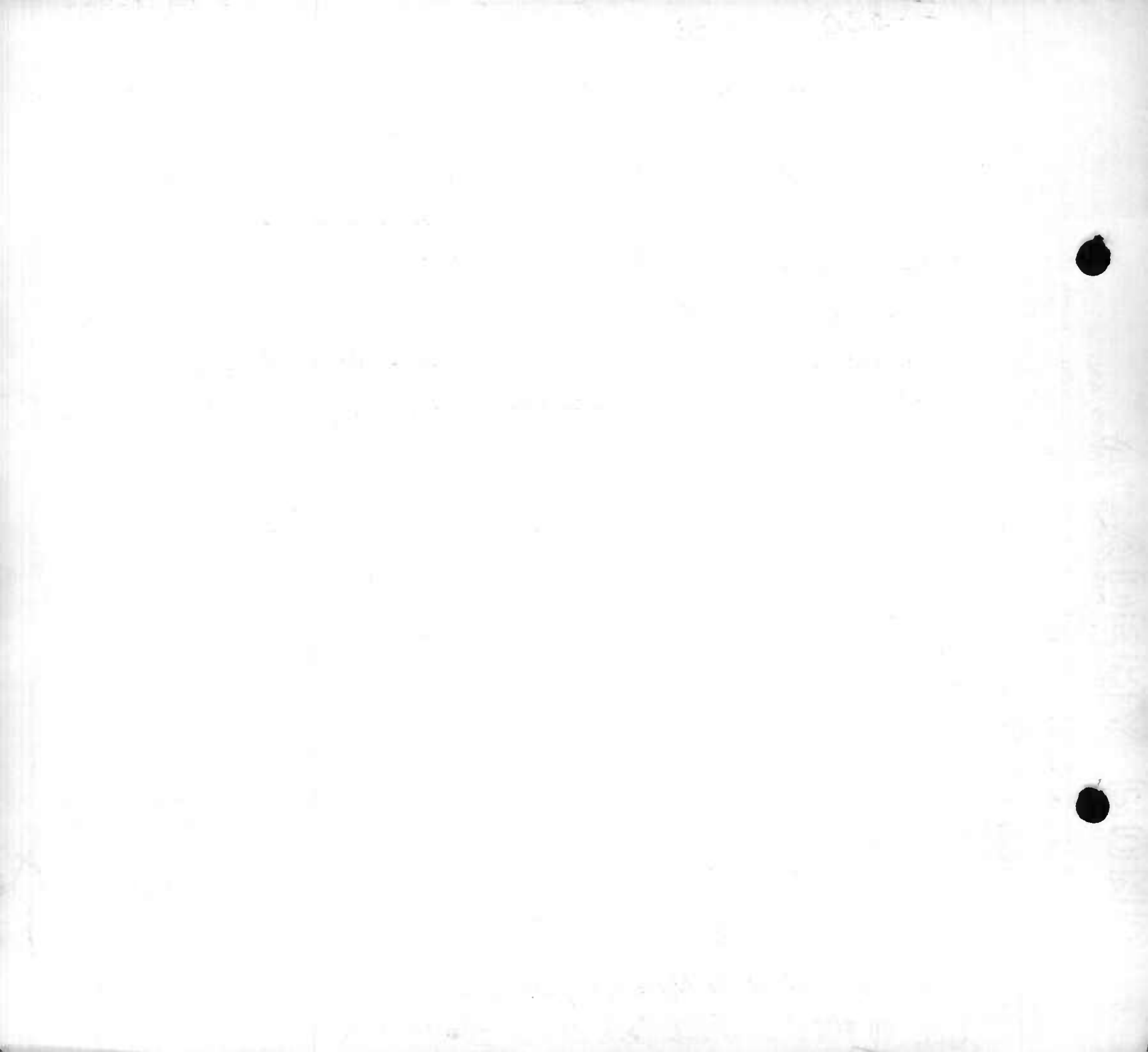
BALTIMORE CITY HEALTH DEPARTMENT				71 12085		71 12085	
S-400 71 12085				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Loula Elmer Sewell				12/29/1971		1 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission).			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  90 Edgewood Nursing Home				A. STATE Maryland		B. COUNTY 2748	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5626 Loch Raven Blvd.							
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/31/1877	9. AGE (In years last birthday) 94	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George H. Elmer			14. MOTHER'S MAIDEN NAME Henrietta Langrall				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-44-3791		17. INFORMANT J-1 Mrs. Clinton C. Davison		
			ADDRESS 3922 Cloverhill Road		21218		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 11 Broncho-Pneumonia (B) 11. Toxic Syndrome (C) Arterio Sclerotic Heart Disease - Cerebral Vascular Sclerosis -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 4 days 10 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1(Month) 1(Day) (Year) 1(Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 9 - 1967 to Dec 29, 1971 that (I) <del>was</del> last saw the deceased alive on Dec 29, 1971 and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <del>did not</del> view the body after death.							
23A. SIGNATURE Earl L. Chambers				23B. DATE SIGNED 12/29/71			
23C. PHYSICIAN'S NAME (Type) Dr. Earl Chambers				23D. ADDRESS 100 W. Coldspring Lane			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/71		24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR H. W. Jenkins & Sons Co.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto., Md. 21212	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		71 12086	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.	
CLARENCE EAST		12/24/71		11 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		1633	
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHN HOPKINS		A. STATE MARYLAND		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 533 N. FULTON AVE.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04/10/12	9. AGE (in years last birthday) 59	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Music	11. BIRTHPLACE (State or foreign country) Baltimore Md	12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME LAWSON, MARY Edward East		14. MOTHER'S MAIDEN NAME EAST, WILLIAM Mary Turner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213 05 2860		17. INFORMANT Mrs Elizabeth East 533 N. Fulton Ave	
18. 400.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0		CAUSE OF DEATH (A) IMMEDIATE CAUSE POSSIBLE ASPIRATION DUE TO, OR AS A CONSEQUENCE OF: (B) BRAINSTEM INFARCT DUE TO, OR AS A CONSEQUENCE OF: (C) MALIGNANT HYPERTENSION CNS LES		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/14 1971 to 12/24 1971 that (I) (we) last saw the deceased alive on 12/24 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Feinglass, MD.		23B. DATE SIGNED 12/24/71			
23C. PHYSICIAN'S NAME (Type) E. FEINGLASS MD.		23D. ADDRESS DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-71		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Ch. Cem	
24D. LOCATION (City, town, or county) (State) Aberdeen Md		25A. DATE REC'D BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR R. Russ	
25C. FUNERAL DIRECTOR R. Russ		25D. ADDRESS 2222 W. North Ave			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. <b>71 12087</b>	
BIRTH NO. <b>H-324 71 12087</b>		1. NAME OF DECEASED (Type or Print) <b>HOWDYSHELL, THOMAS LESTER</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 31 1971 7:55A</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2005</b>		5. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST. AGNES HOSPITAL CATON &amp; WILKENS AVENUE BALTIMORE MARYLAND 21229</b>		6. DATE OF BIRTH <b>06 03 03</b>		9. AGE (in years last birthday) <b>68</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BRICK LAYER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
13. FATHER'S NAME <b>GEORGE HOWDYSHELL</b>		14. MOTHER'S MAIDEN NAME <b>ANNA (HARMON) HOWDYSHELL</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>230 01 9320</b>		17. INFORMANT <b>WILKENS AVENUE 21229 ADDRESS</b>	
18. <b>491X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Chronic Obstructive Pulmonary Disease</b>		CAUSE OF DEATH <b>Chronic Bronchitis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>NOVEMBER 29 1971</b> to <b>DECEMBER 31 1971</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DECEMBER 31 1971</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <b>Joseph H. Miller, MD</b>		23B. DATE SIGNED <b>12/31/71</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSEPH H. MILLER, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/3/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>		25B. NAME OF REGISTRAR <b>John C. Miller</b>		25C. FUNERAL DIRECTOR <b>2101 Frederick Ave</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25D. ADDRESS <b>2101 Frederick Ave</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <b>71 12088</b>	
BIRTH NO. <b>71 12088</b>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>Frederick W. PFISTER</b>			2. DATE AND HOUR OF DEATH <b>12-31-1971</b> <span style="float: right;">1 2 P.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27+8</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hospital 1-7-72</b>			C. CITY OR TOWN <b>Balto</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>CERTIFICATE AMENDED</b>			E. STREET AND NUMBER <b>5651 Purdue Ave Balto 21239</b>		
5. SEX <b>m</b>	6. RACE <b>w</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01-31-94</b>	9. AGE (in years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BANKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MCNATEL BANK</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>	
13. FATHER'S NAME <b>ADOLPH PFISTER</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII 391-20-0470</b>			16. SOCIAL SECURITY NO. <b>391-20-0470</b>		
17. INFORMANT <b>ETHEL</b>			ADDRESS <b>MRS. EDITH M. PFISTER (SAME)</b>		
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>(WIFE) Cause ill 1 mos.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CAUSE III</b>		
(B) DUE TO, OR AS A CONSEQUENCE OF:			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-30</b> 19 <b>71</b> to <b>12-31</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12-31</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I) (We) (did)</u> (did not) view the body after death.					
23A. SIGNATURE <b>TULLIO BERTORINI</b>				23B. DATE SIGNED <b>12-31-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>TULLIO BERTORINI</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-4-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>	
24D. LOCATION <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>			
25B. NAME OF REGISTRAR <b>John L. Jenkins</b>		25C. FUNERAL DIRECTOR <b>H. O. Jenkins &amp; Sons Co.</b>			
ADDRESS <b>14905 York Road Balto., Md. 21212</b>					

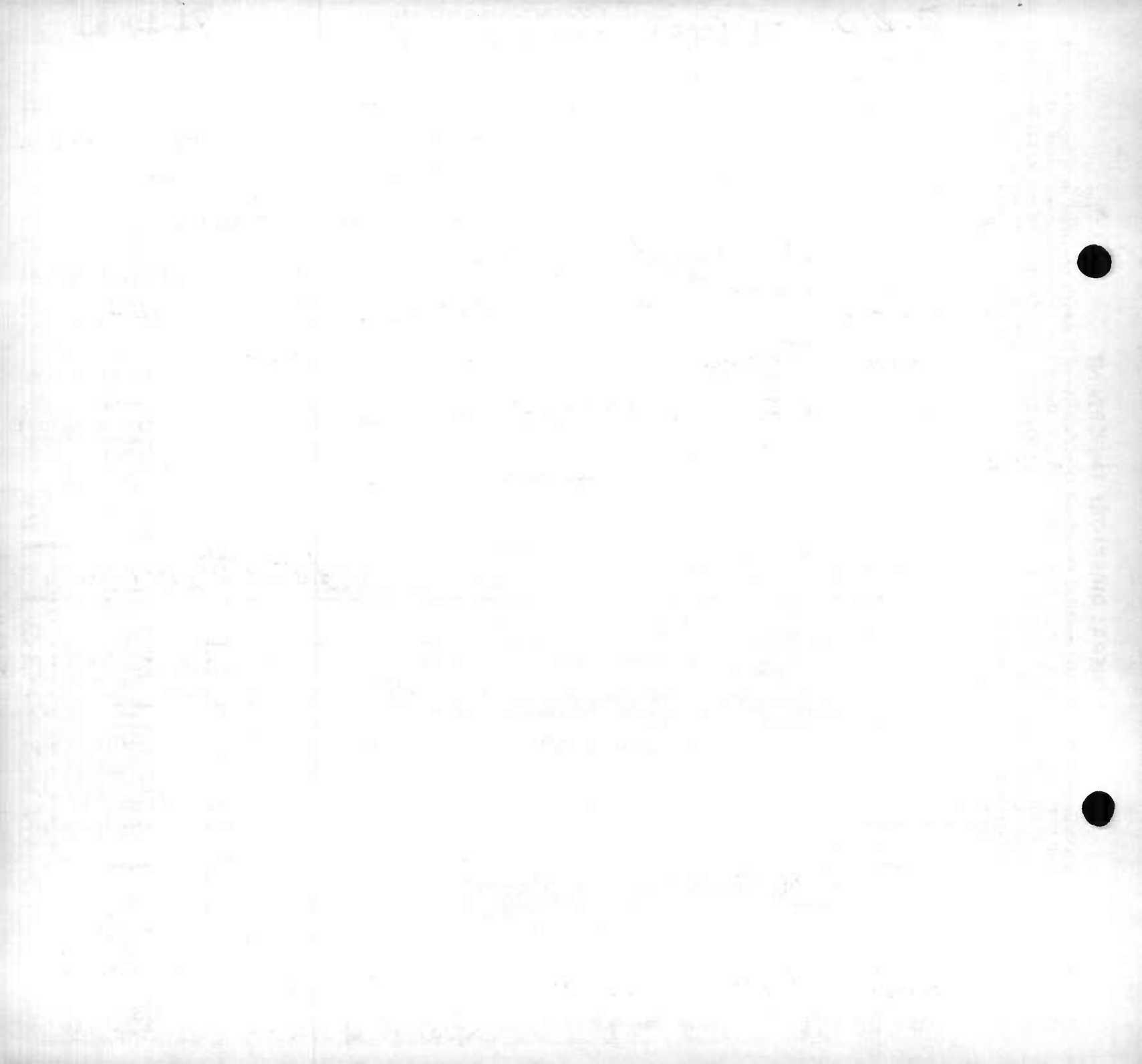
1-7-72 - Correction form from Funeral Director

HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>G-400</b></span> <span><b>71 12089</b></span> <span><b>BALTIMORE CITY HEALTH DEPARTMENT</b></span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>CERTIFICATE OF DEATH</b></span> <span><b>REG. NO. 71 12089</b></span> </div>			
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <b>HARRY GILL</b>		2. DATE AND HOUR OF DEATH <b>12. 31. 71</b> <b>2:45 pm</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b> <b>+3</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____ C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2416 Harbourn Avenue</b> <b>2572</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-08</b>
9. AGE (in years last birthday) <b>63</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>chauffer</b> 10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Theodore Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Laura Crowther</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>215-03-6225</b>	
17. INFORMANT <b>R. Sirithara</b>		ADDRESS <b>South Baltimore General Hospital</b>	
18. <b>571.8 I</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchopneumonia</b>  (B) <b>Encephalopathy</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Hepatic failure due to portal cirrhosis</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2 w</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>wil</b>	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <b>wil</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>wil</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>wil</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>wil</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>wil</b>	
22. I certify that (H) (this hospital) attended the deceased from <b>12. 22. 19 71</b> to <b>12. 31. 19 71</b> that (H) (we) last saw the deceased alive on <b>12. 31. 19 71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>R. Sirithara</b> <b>M.D.</b>		23B. DATE SIGNED <b>12 / 31 / 71</b>	
23C. PHYSICIAN'S NAME (Type) <b>R. SIRITHARA M.D.</b>		23D. ADDRESS <b>South Baltimore General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/4/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Criders Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>St. Bonifacius Lutheran Church Carroll Co, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>		25B. NAME OF REGISTRAR <b>R. Sirithara, M.D.</b>	
25C. FUNERAL DIRECTOR <b>J. Schwartz, Inc.</b>		ADDRESS <b>Frederick Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 12090	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. 4-620 71 12090		1. NAME OF DECEASED (Type or Print) <b>Harris, Mamie</b>		2. DATE AND HOUR OF DEATH <b>12-31-71 1:40 a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1601</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>903 Harlem Ave.</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>09-15-00</b>	9. AGE (in years, lost birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>215-07-2650</b>		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CHF</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASHCVD</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Uremia</b> (C) <b>Uremia</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-27</b> 19 <b>71</b> to <b>12-31</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12-31</b> 19 <b>71</b> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. G. Mercado</b>		23B. DATE SIGNED <b>12/31/71</b>		23C. PHYSICIAN'S NAME (Type) <b>M. G. Mercado</b>	
23D. ADDRESS <b>Provident Hospital Balt. Md.</b>		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-4-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>mt Auburn</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>			
25B. NAME OF REGISTRAR <b>Robert C. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>Q. W. S. Hughes</b>		25D. ADDRESS <b>1532 Hollins St</b>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12091

BIRTH NO.

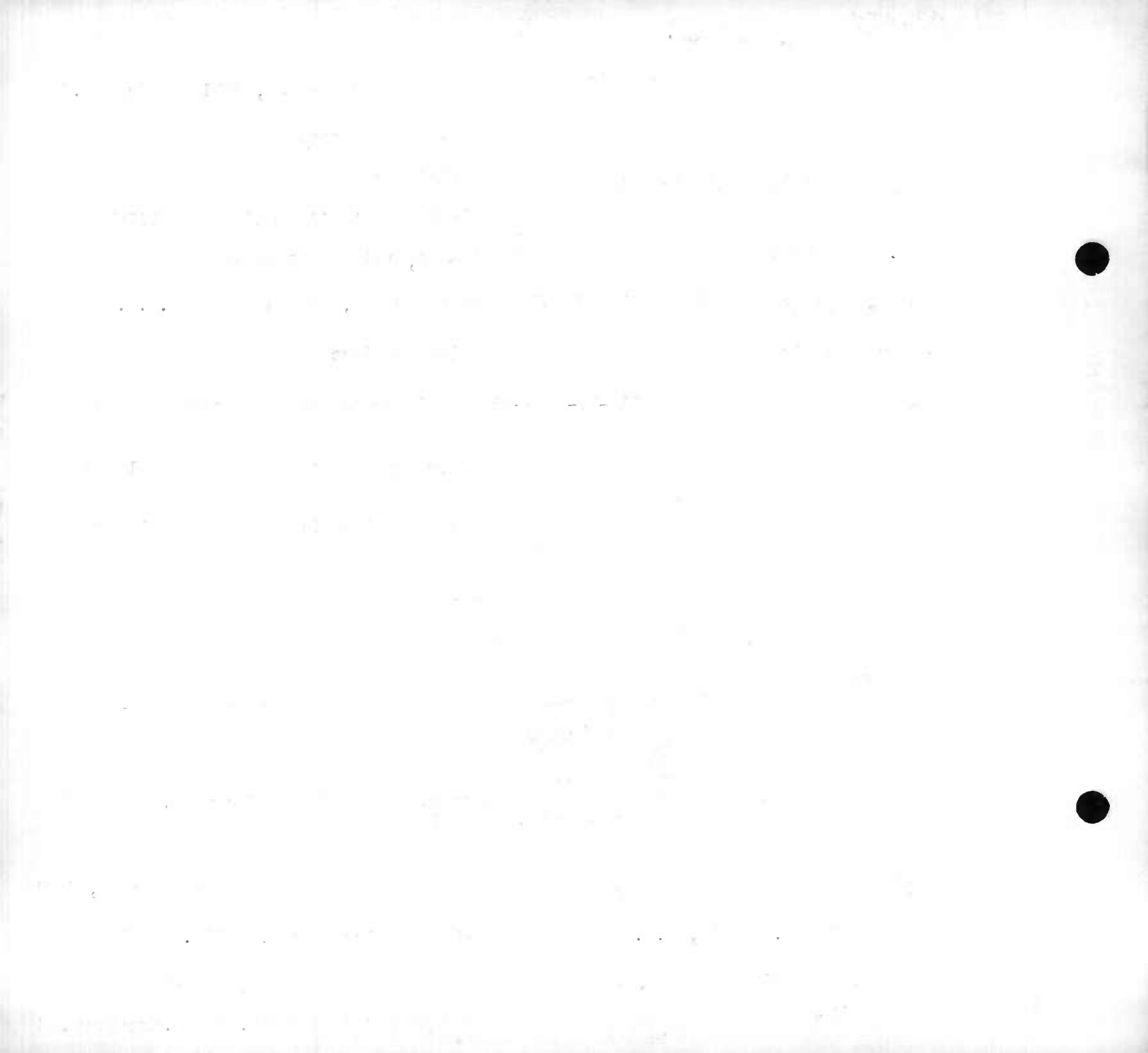
1. NAME OF DECEASED (Type or Print) John C. Krauder		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 23 Year 71 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		3. DATE PRONOUNCED DEAD Month 12 Day 23 Year 71 Hour 11:45 P.M.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Sept. 10, 1900		10. AGE (in years last birthday) 71	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Farmer - Painter, etc.		14B. KIND OF BUSINESS OR INDUSTRY Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI & WWII		17. SOCIAL SECURITY NO. 215-10-1801	
18. INFORMANT Friend: Miss Margaret Kelly, 141 E. North Ave.		ADDRESS 21202	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION ○		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/24/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/71	
24C. NAME OF CEMETERY or CREMATORY Gettysburg National Cem.		24D. LOCATION (City, town, or county) (State) Gettysburg, Penna.	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR J. E. ...	
25C. FUNERAL DIRECTOR STEWART & MOWEN CO.		ADDRESS 21201 108 W. NORTH AVE.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT REG. NO. <span style="font-size: 1.5em;">71 12092</span>			
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">M-252 71 12092</span> Sister Anna McGinnis		<b>2. DATE AND HOUR OF DEATH</b> December 29, 1971 6:00 P.M.	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <span style="font-size: 1.5em;">94</span> Villa Saint Michael		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">2841</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> 4000 Forest Hill Road 21207	
<b>5. SEX</b> F.	<b>6. RACE</b> White	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Nurse - retired		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> Sister of Charity	
<b>13. FATHER'S NAME</b> James McGinnis		<b>14. MOTHER'S MAIDEN NAME</b> Elizabeth Kane	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) No		<b>16. SOCIAL SECURITY NO.</b> 219-54-0602-J1	
<b>17. INFORMANT</b> Sister Andrea		<b>ADDRESS</b> same address	
<b>18. CAUSE OF DEATH</b>			
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> 1 day  10 years(?)	
<b>II</b>			
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>			
<b>19A. DATE OF OPERATION</b> <input type="radio"/> None		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) No injury	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">December, 1962</span> <b>to</b> <span style="font-size: 1.2em;">December, 1971</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">December 28, 1971</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>			
<b>23A. SIGNATURE</b> 		<b>23B. DATE SIGNED</b> December 30, 1971	
<b>23C. PHYSICIAN'S NAME (Type)</b> Damian P. Alagia, M.D.		<b>23D. ADDRESS</b> 3326 Frederick Avenue, Balto. 21228	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> BURIAL		<b>24B. DATE</b> 12/31/71	
<b>24C. NAME of CEMETERY or CREMATORY</b> St. Joseph's Cemetery		<b>24D. LOCATION</b> (City, town, or county) (State) Emmitsburg, Maryland	
<b>25A. DATE REC'D BY HEALTH DEPT</b> <span style="font-size: 1.5em;">JAN 3 1972</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.5em;">R. E. J. ...</span>	
<b>25C. FUNERAL DIRECTOR</b> STEWART & MOWEN CO.		<b>ADDRESS</b> 108 W. North Av. 1	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-244-1		C-200 71 12093		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12093	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>McClellan Mrs. Katherine Causey</b>		2. DATE AND HOUR OF DEATH <b>12-30-71 6.00 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		2713	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Keswick Home for Incurables of Baltimore City - 700 W. 40th. St.</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>				6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>12-17-93</b>	
13. FATHER'S NAME <b>Boone Edmund Lockett</b>				14. MOTHER'S MAIDEN NAME <b>Marjorie Hersh</b>		9. AGE (In years last birthday) <b>78</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW1 ---</b>				16. SOCIAL SECURITY NO. <b>215-48-8980</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
17. INFORMANT <b>Keswick 700 W. 40th St.</b>				ADDRESS			
18. <b>486 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Cerebral arteriosclerosis (senility)</b> <b>Bladder stones</b>						10 years 15 years	
19A. DATE OF OPERATION <b>6/13/56</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>he</b> (this hospital) attended the deceased from <b>6/13/56</b> 19 to <b>12/30/71</b> 19 that <b>he</b> (we) last saw the deceased alive on <b>12/30/71</b> 19 and that in <b>our</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>he</b> (We) (did) (view) view the body after death.							
23A. SIGNATURE <b>W.B. Daniels, Jr. M.D.</b>				23B. DATE SIGNED <b>12/31/71</b>			
23C. PHYSICIAN'S NAME (Type) <b>W. B. DANIELS, Jr.</b>				23D. ADDRESS <b>700 W. 40th St. Keswick Baltimore 21211</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JAN. 12/1/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Thomas' Ep. Ch. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Garrison Forest, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Stewart &amp; Mowen</b>		25C. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN</b>		ADDRESS <b>CO. 108 W. North Av. City</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-534		71 12094		BALTIMORE CITY HEALTH DEPARTMENT		71 12094	
CERTIFICATE OF DEATH		REG. NO.					
1. NAME OF DECEASED (Type or Print)		Pendleton, Revella		2. DATE AND HOUR OF DEATH		December 30, 1971 5 15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Md.		B. COUNTY Baltimore	
39 Provident Hosp.				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER		879 Bethesda St.	
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-31-04	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harvey Pat Sr.				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-18419		17. INFORMANT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Arteriosclerotic Heart Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				Malnutrition			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 12-1-71 to 12-30-71 that (I) (we) lost saw the deceased alive on 12-30-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE V. Chitraplee				23B. DATE SIGNED Dec. 30, 71			
23C. PHYSICIAN'S NAME (Type) Vadhana Chitraplee				23D. ADDRESS Provident Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-3-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR A. W. Wright		ADDRESS 2700 Edmondson Ave.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

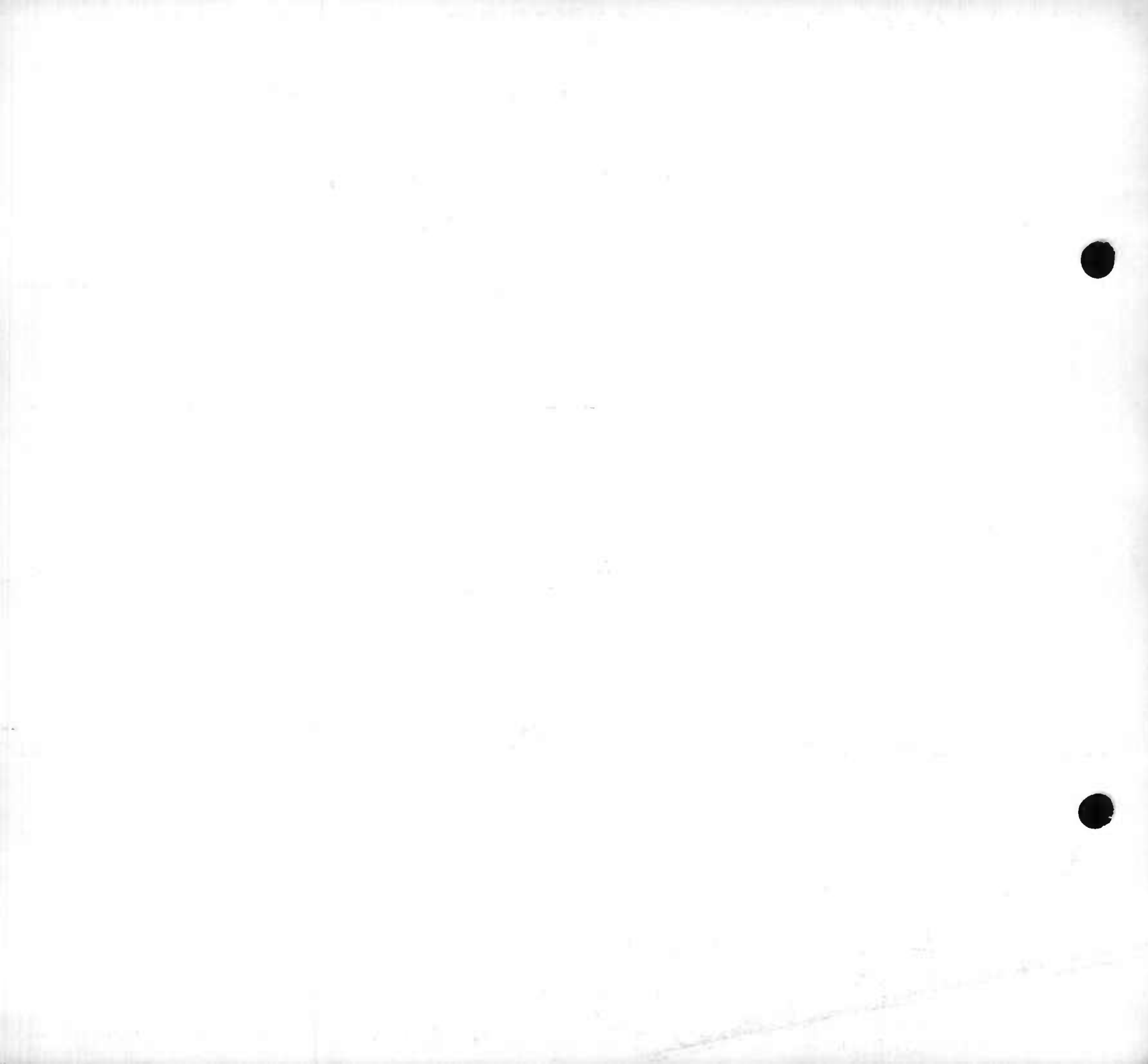
71 12095		BALTIMORE CITY HEALTH DEPARTMENT		71 12095	
S-162 71 12095		CERTIFICATE OF DEATH		REG. NO. _____	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <u>Joseph Spears</u>		2. DATE AND HOUR OF DEATH <u>12/25/71</u> <u>8:00 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u> <u>38</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1402</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>Black</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/15/18</u> 9. AGE (in years lost birthday) <u>53</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME _____		14. MOTHER'S MAIDEN NAME _____		12. CITIZEN OF WHAT COUNTRY? _____	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>?????</u> <u>237-16-3704</u>		17. INFORMANT <u>Miss Joan Spears, 810 W 8<sup>th</sup> Ratoga St</u> ADDRESS _____	
MEDICAL CERTIFICATION  18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(A) IMMEDIATE CAUSE <u>Sepsis, 2° to aspiration pneumonia</u>		<u>4-5 days</u>	
		(B) <u>Coma, 2° to cardiac arrest</u>		<u>29 days</u>	
		(C) <u>Klebsiella Septicemia, 2° to Perforated Ulcer</u>		<u>30 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Perforated Gastric &amp; Duodenal ulcers</u>				<u>30 Days</u>	
19A. DATE OF OPERATION <u>0 8</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>November 27</u> 19 <u>71</u> to <u>December 25</u> 19 <u>71</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>December 25</u> 19 <u>71</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Richard A. Tomasulo M.D.</u> DEGREE _____				23B. DATE SIGNED <u>Dec 25, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard A. Tomasulo</u>		23D. ADDRESS <u>Univ. of Maryland Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/31/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) <u>AA County Md</u>		24E. LOCATION (City, town, or county) (State) _____			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>John E. Jelen</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u> ADDRESS <u>1206 W North Ave</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

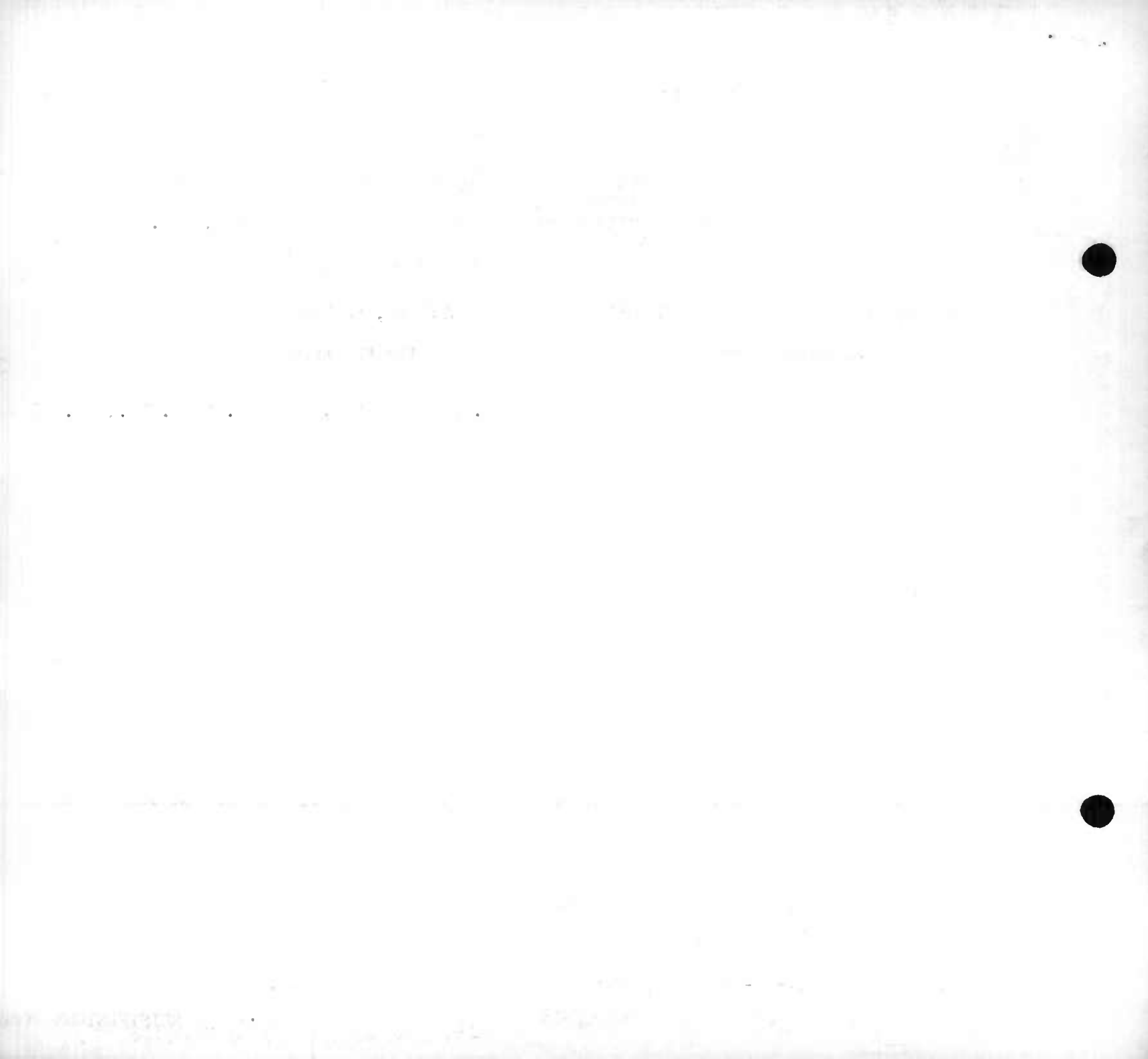
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 12096</b>
<b>W-435 71 12096</b> <b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>James Walton (A) (H)</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>12/29/71 12:40 P.M.</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>38 University of Md. Hospital</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>1602</b>  <b>5. CITY OR TOWN</b> <b>Baltimore,</b> <b>6. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>  <b>7. STREET AND NUMBER</b> <b>1310 Harlem Ave</b>		
<b>5. SEX</b> <b>M</b> <b>6. RACE</b> <b>N</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1900</b> <b>9. AGE</b> (In years last birthday) <b>71</b> <b>10. If Under 1 Tr. Months Days</b> <b>11. If Under 24 Hrs. Hours Min.</b>		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Union S C</b> <b>12. CITIZEN OF WHAT COUNTRY</b> <b>U S A</b>		
<b>13. FATHER'S NAME</b> <b>George Walten</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Malinda</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>212-10-1955</b> <b>17. INFORMANT</b> <b>Mr Robert Walton, 1011 Somerset ST</b> <b>ADDRESS</b>		
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>19A. DATE OF OPERATION</b> <b>12/29/71</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>Carcinoma of lung</b> <b>20A. AUTOPSY?</b> (Yes or No) <b>Yes</b> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>Yes</b>				
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> <b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from 12/23/71 to 12/29/71 that (I) (we) last saw the deceased alive on 12/29/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>		<b>23A. SIGNATURE</b> <b>Louis E. Grenzer</b> <b>Attending Phys.</b> <input checked="" type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input type="checkbox"/> <b>23B. DATE SIGNED</b> <b>12/29/71</b>		
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>LOUIS E. GRENZER</b>		<b>23D. ADDRESS</b>		
<b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>1/3/72</b> <b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Spartenberg</b> <b>24D. LOCATION</b> (City, town, or county) (State) <b>South Carolina</b>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 3 1972</b>		<b>25B. NAME OF REGISTRAR</b> <b>Adolphus Halstead</b> <b>25C. FUNERAL DIRECTOR</b> <b>Adolphus Halstead</b> <b>ADDRESS</b> <b>1206 W North Ave</b>		



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				71 12097	
CERTIFICATE OF DEATH				REG. NO. 71 12097	
BIRTH NO. 11-53971 12097		1. NAME OF DECEASED (Type or Print) <u>Mary Mandel</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>27 Dec 1971</u> <u>7:50 A.M.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Good Samaritan Hospital</u> <u>5601 Loch Raven Blvd. Baltimore 21239</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2730</u>			
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		8. DATE OF BIRTH <u>2 Jan 1906</u> 9. AGE (in years last birthday) <u>65</u>	
13. FATHER'S NAME <u>BERNARD KERNS</u>		14. MOTHER'S MAIDEN NAME <u>IDA PETERSON</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>312-07-6383</u>		17. INFORMANT <u>MR. DAVID MANDEL, 7111 PK. HIGHTS. AVE., APT. 807</u> ADDRESS	
18. <u>174 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		CAUSE OF DEATH <u>Carcinoma of Breast, metastatic</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>&gt; 3 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>11/19</u> 19 <u>71</u> to <u>12/27</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>12/27</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard J. Owellen</u>		23B. DATE SIGNED <u>12/27/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Richard J. Owellen</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-28-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>OHLE YAKOV</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson</u>	
26A. ADDRESS <u>6010 REISTERSTOWN ROAD</u>		26B. CITY <u>BALTIMORE</u>		26C. STATE <u>MARYLAND</u>	



# FUNERAL DIRECTOR: IMPORTANT

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R-150/1 12098		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12098	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) RUBIN, MICHAEL		2. DATE AND HOUR OF DEATH 12/07/71 2:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hosp of Baltimore, Inc.		E. STREET AND NUMBER 5939 WESTERN PARK DRIVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 67	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) LONDON, ENGLAND	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME ALEXANDER RUBIN		14. MOTHER'S MAIDEN NAME RACHAEL ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-32-8312		17. INFORMANT MRS. JULIA RUBIN, 5939 WESTERN PARK DRIVE #9	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 41231-25019		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sev. days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Chronic Renal Failure		sev. yrs.	
(C) ASCVD (Atherosclerotic Heart Disease)				sev. yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Diabetes Mellitus, CHF		sev. yrs.	
19A. DATE OF OPERATION 5		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-6 19 21 to 12-27 19 71 that (I) (we) last saw the deceased alive on 12-27 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gerardo C. Germino		23B. DATE SIGNED 12/27/71		23C. PHYSICIAN'S NAME (Type) GERARDO C. GERMINO	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-28-71		24C. NAME OF CEMETERY OR CREMATORY BOBROISKER BENEFICIAL CIRCLE, ROSEDALE, MARYLAND	
25A. DATE RECEIVED BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR J. E. Faller, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

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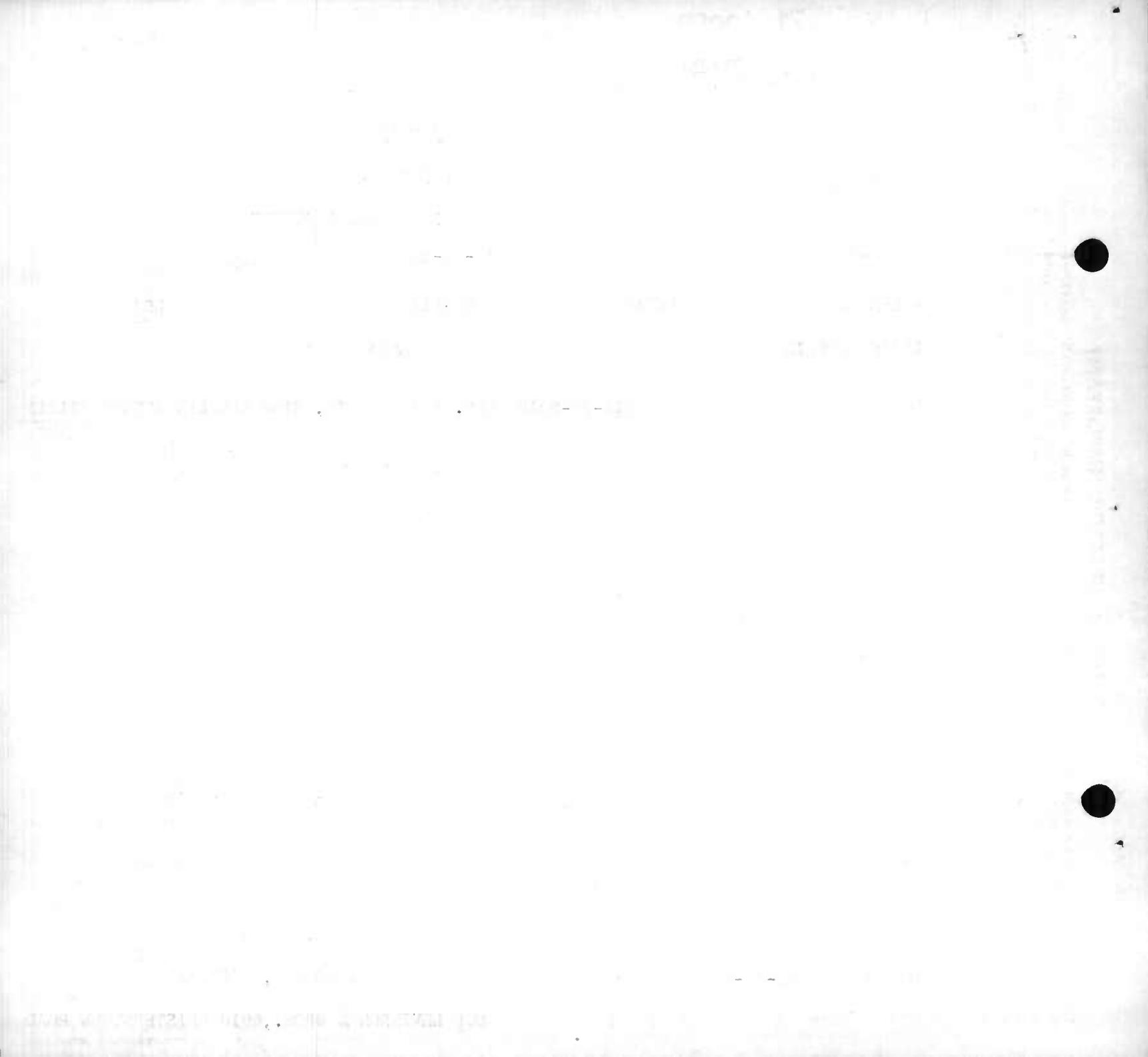
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12099</u>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>IRVING DWORKIN</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>12/26/71</u> <u>7:15 P.</u> M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2831</u> <b>C. CITY OR TOWN</b> <u>BALTIMORE</u> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>4100 NEWBERN AVENUE</u>		
<b>5. SEX</b> <u>MALE</u>	<b>6. RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12-25-1906</u>	<b>9. AGE</b> (In years last birthday) <u>65</u> If Under 1 Yr. Months: Days: Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>RETAIL</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>RUSSIA</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>ISAAC DWORKIN</u>		
<b>14. MOTHER'S MAIDEN NAME</b> <u>ANNA ?</u>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
<b>16. SOCIAL SECURITY NO.</b> <u>215-10-9049</u>		<b>17. INFORMANT</b> <u>MRS. IDA DWORKIN, 4100 NEWBERN AVENUE #21215</u> <b>ADDRESS</b>		
<b>18. CAUSE OF DEATH</b> <u>410.9.1-25.0.9</u> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u> (B) <u>ASHD + Diabetes</u> (C)				
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>19 60</u> <b>to</b> <u>12/26</u> <b>19</b> <u>71</u> <b>that (I) (we) last saw the deceased alive on</b> <u>12/5</u> <b>19</b> <u>71</u> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>Leonard M. Lister</u>		<b>23B. DATE SIGNED</b> <u>12/26/71</u>		<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Leonard M. Lister M.D.</u>
<b>23D. ADDRESS</b> <u>7111 Park Heights Ave</u>		<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		
<b>24B. DATE</b> <u>12-28-71</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>BETH JACOB</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>FINKSBURG, MARYLAND</u>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 3 1972</u>		<b>25B. NAME OF REGISTRAR</b> <u>John E. ...</u>		<b>25C. FUNERAL DIRECTOR</b> <u>SOI LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u> <b>ADDRESS</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. 71 12100	
7-450 71 12100							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GENEVIEVE FLYNN</b>			2. DATE AND HOUR OF DEATH <b>12/28/71 5:19 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Balto General Hosp</b> <b>3001 So. Hanover St</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>BALTO.</b>		B. COUNTY <b>BALTO</b>	
				C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>909 VICTORY AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>6-28-27</b>	9. AGE (in years last birthday) <b>44</b>	10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITRESS</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>James Brown</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Pennington</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>247-44-0969</b>		17. INFORMANT <b>Elsie Idleman Elizabeth Rd</b>			
18. <b>CAUSE OF DEATH</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrest</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>metastatic ca of cervix</b>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 27 1971</b> to <b>Dec 28 1971</b> that (I) (we) last saw the deceased alive on <b>Dec 28 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Geo Juh Noh M.D.</b>				23B. DATE SIGNED <b>Dec 28/71</b>		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS <b>South Baltimore General Hospital</b>				23E. FUNERAL DIRECTOR <b>Raymond C Fink</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Raymond C Fink</b>		25C. ADDRESS <b>Glen Burnie, Md.</b>		25D. FUNERAL DIRECTOR <b>Raymond C Fink</b>	

34A Victory Ave

Waitress Restaurant

44

G-626

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12101

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Greiser		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 27 71 9:25 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital		3. DATE PRONOUNCED DEAD 12 27 71 9:25 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1-4-1907		10. AGE (In years lost birthday) 64	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		14B. KIND OF BUSINESS OR INDUSTRY Hecht Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 213-09-7379	
18. INFORMANT Marie Greiser		ADDRESS 1109 S. Ellwood Avenue	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 12-28-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-71	
24C. NAME OF CEMETERY or CREMATORY Loudon Pk. Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Helmuth Hoffmann		ADDRESS 3218 Hudson St.	

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

MEMORANDUM FOR THE DIRECTOR

FROM: ASST. DIR. FOR LAND MANAGEMENT

SUBJECT: [Illegible]

DATE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

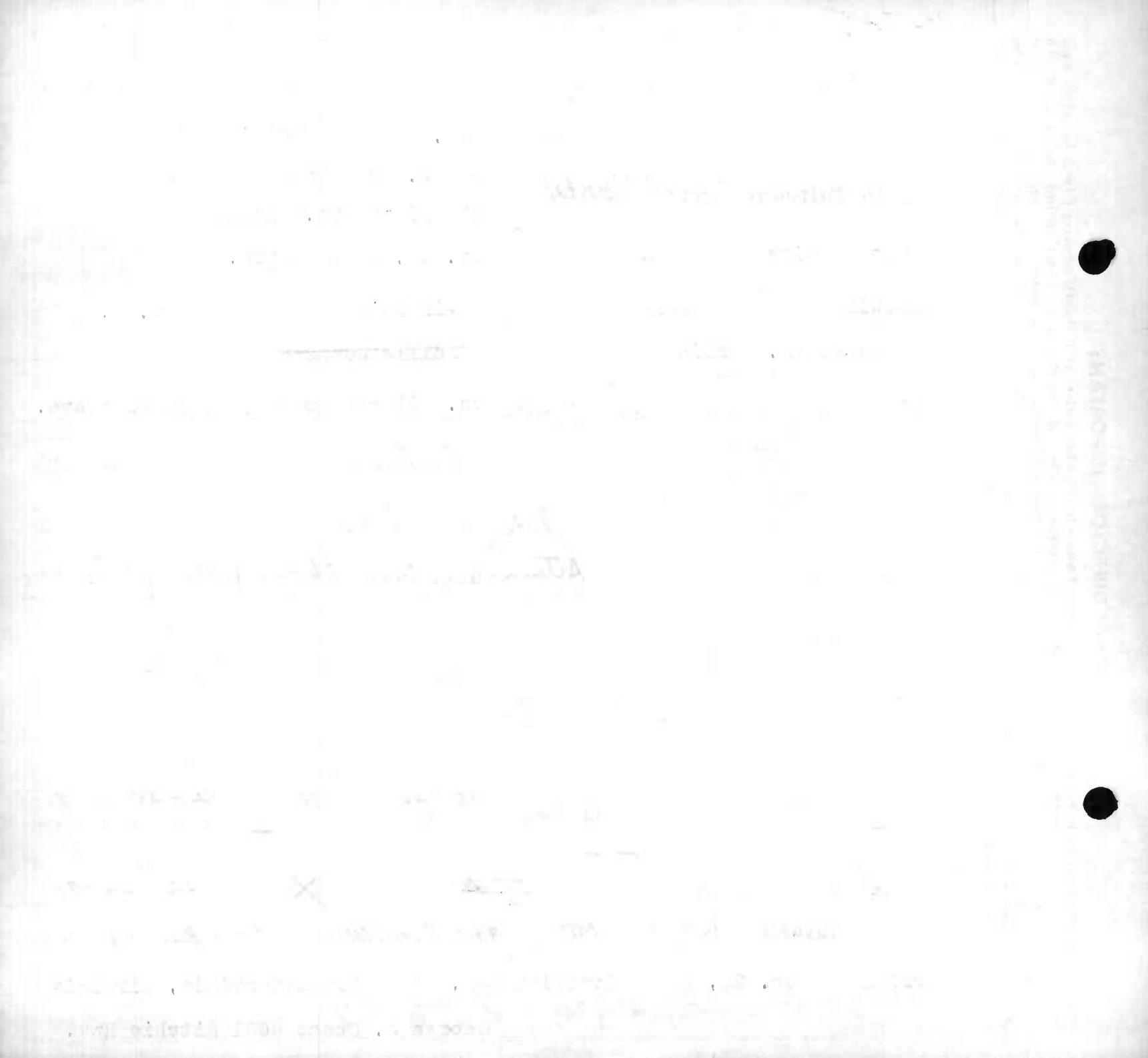
15. [Illegible]

16. [Illegible]

17. [Illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 12102	
BIRTH NO. <b>K-530</b>		71 12102					
1. NAME OF DECEASED (Type or Print) <b>Lucille M. Kennedy</b>				2. DATE AND HOUR OF DEATH <b>12 - 25 - 71</b> <b>8:22 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>43 South Baltimore General Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> <b>5300</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b>				C. CITY OR TOWN <b>Balto. Suburban</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>736 Fifth Ave. 21227</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 13, 1910</b>		9. AGE (In years last birthday) <b>61 yrs.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Samuel A. Morris</b>				14. MOTHER'S MAIDEN NAME <b>Mollie Johnson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>226 07 2103</b>		17. INFORMANT ADDRESS <b>Mrs. Mildred McGee 3003 Florida Ave.</b>			
18. <b>440.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Cachexia</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) Intestinal fistula</b> <b>(C) Anterior abdominal wall - Chronic pylorospasm, severe</b> <b>(D) Anterior abdominal wall - Chronic pylorospasm, severe</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>21</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10 - 20</b> 19 <b>71</b> to <b>12 - 25</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12 - 25</b> 19 <b>71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Susumu Kinjo</b>				23B. DATE SIGNED <b>12 - 25 - 71</b>		23C. PHYSICIAN'S NAME (Type) <b>Susumu Kinjo MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec. 28, 1971</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Riverview Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Charlottesville, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 8 1972</b>		25B. NAME OF REGISTRAR <b>George J. Gonce</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George J. Gonce 4001 Ritchie Hwy.</b>			

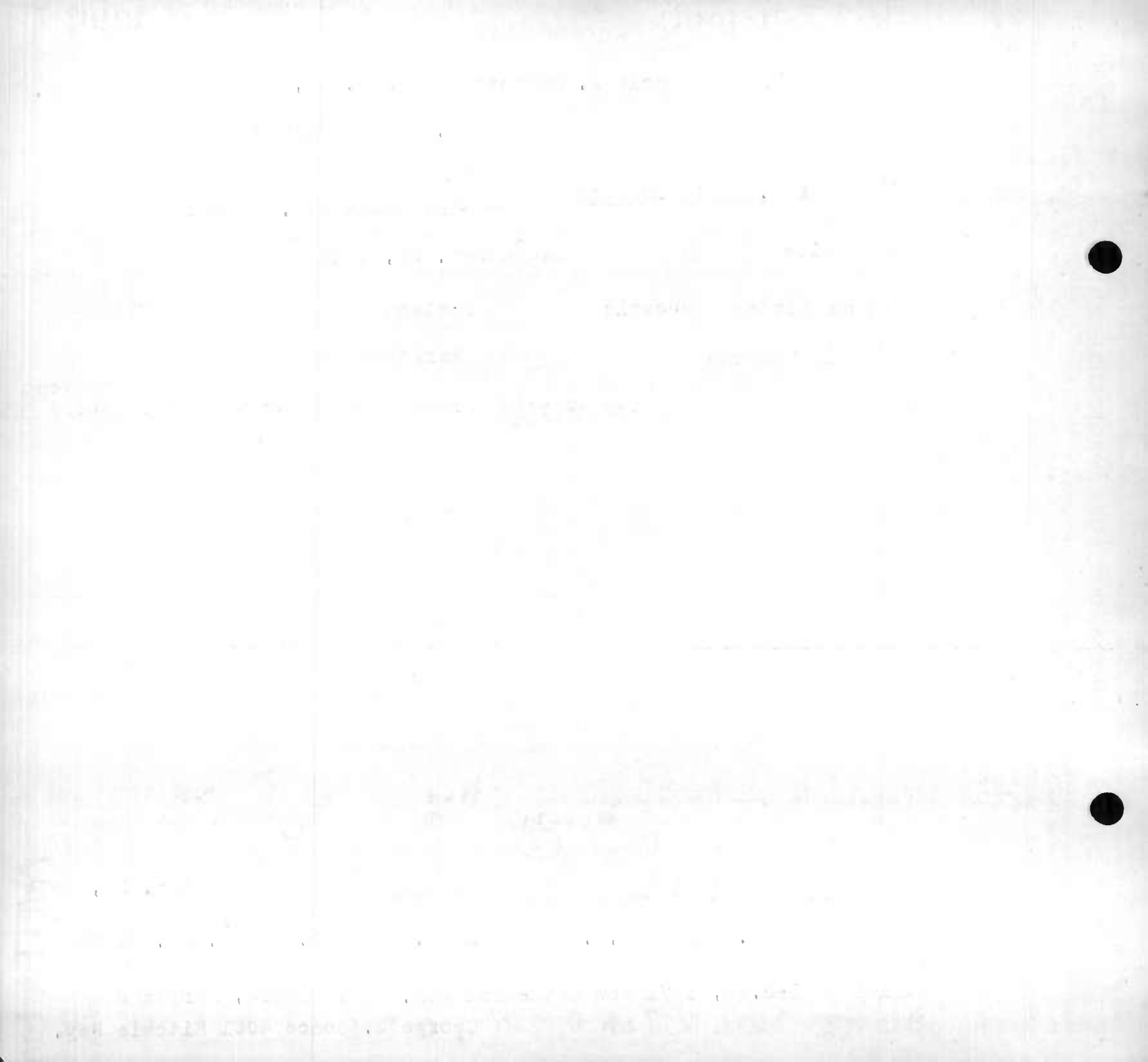




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">71 12103</span>	
BIRTH NO. <span style="float: right;">11-500 71 12103</span>		1. NAME OF DECEASED (Type or Print) <b>Mary Francis X. Mahoney</b>		2. DATE AND HOUR OF DEATH <b>Dec. 25, 1971 1:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>40 1st. Agnes Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Halethorpe</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>4100 Maple Ave.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 29, 1887</b>	9. AGE (In years last birthday) <b>84</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Religious Sister</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Ireland</b>		13. FATHER'S NAME <b>Martin Mahoney</b>			
14. MOTHER'S MAIDEN NAME <b>Margaret Murray</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>199 40 5665</b>		17. INFORMANT <b>Sister Mary Dolores Good Shepherd</b>			
18. ADDRESS <b>Convent</b>		19. CAUSE OF DEATH <b>431.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral hemorrhage</b> <b>Cerebral arteriosclerosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>			
20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
22. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1968</b> to <b>1971</b> that (I) (we) last saw the deceased alive on <b>Dec 21</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I) (We) (did) (did not)</b> view the body after death.					
23A. SIGNATURE <b>Aidan E. Walsh</b>		23B. DATE SIGNED <b>Dec. 27, 1971</b>		23C. PHYSICIAN'S NAME (Type) <b>Aidan E. Walsh M.D.</b>	
23D. ADDRESS <b>222 St. Paul St. Balto. Md. 21202</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>Dec. 28, 1971</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, Md.</b>		25C. FUNERAL DIRECTOR <b>George U. Gonce</b>	
25D. ADDRESS <b>4001 Ritchie Hwy.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-615 71 12104		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12104	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>James B Carpenter</u>		2. DATE AND HOUR OF DEATH <u>12-30-71</u> <u>12<sup>36</sup></u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1606</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital of Md</u> <u>730 Ashburton St</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6-29-1887</u>		9. AGE (in years last birthday) <u>84</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>	
10A. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen Carpenter</u>		14. MOTHER'S MAIDEN NAME <u>Unkn.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Ella Carpenter</u> <u>Vernita Robinson</u> <u>Same</u>	
18. <u>41231</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>A. S. H. D.</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-23</u> 19 <u>71</u> to <u>12-30</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12-23-19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Barby Calin</u>		23B. DATE SIGNED <u>12-31-71</u>		23C. PHYSICIAN'S NAME (Type) <u>BARBY CALIN</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1/3/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>MOYTON &amp; DYETT</u>	
25C. FUNERAL DIRECTOR ADDRESS <u>1701 LAURENS ST.</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-420 71 12105				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12105	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
				2. DATE AND HOUR OF DEATH 12/27/71 1:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) NORTH CHARLES GEN'L HOSPITAL 49				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3907 RIMMER RD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/12/94	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME STANLEY MILUKAS				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 195-09-8196		17. INFORMANT Hospital Chart		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I 124 X Carcinoma of Breasts - generalized metastasis 8 hours 1 year				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/18/71 to 12/27/71 that (I) (we) last saw the deceased alive on 12/27/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Veena Sathirakul, M.D.				23B. DATE SIGNED 12/27/71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) VEENA		23D. ADDRESS SATHIRAKUL, M.D. North Charles Gen. Hosp					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/71		24C. NAME OF CEMETERY or CREMATORY St. Casimirs		24D. LOCATION (City, town, or county) (State) Muhlenberg Penn.	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR J. E. Johnson		25C. FUNERAL DIRECTOR William E. Johnson		ADDRESS Balto. Md.	

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BALTIMORE CITY HEALTH DEPARTMENT

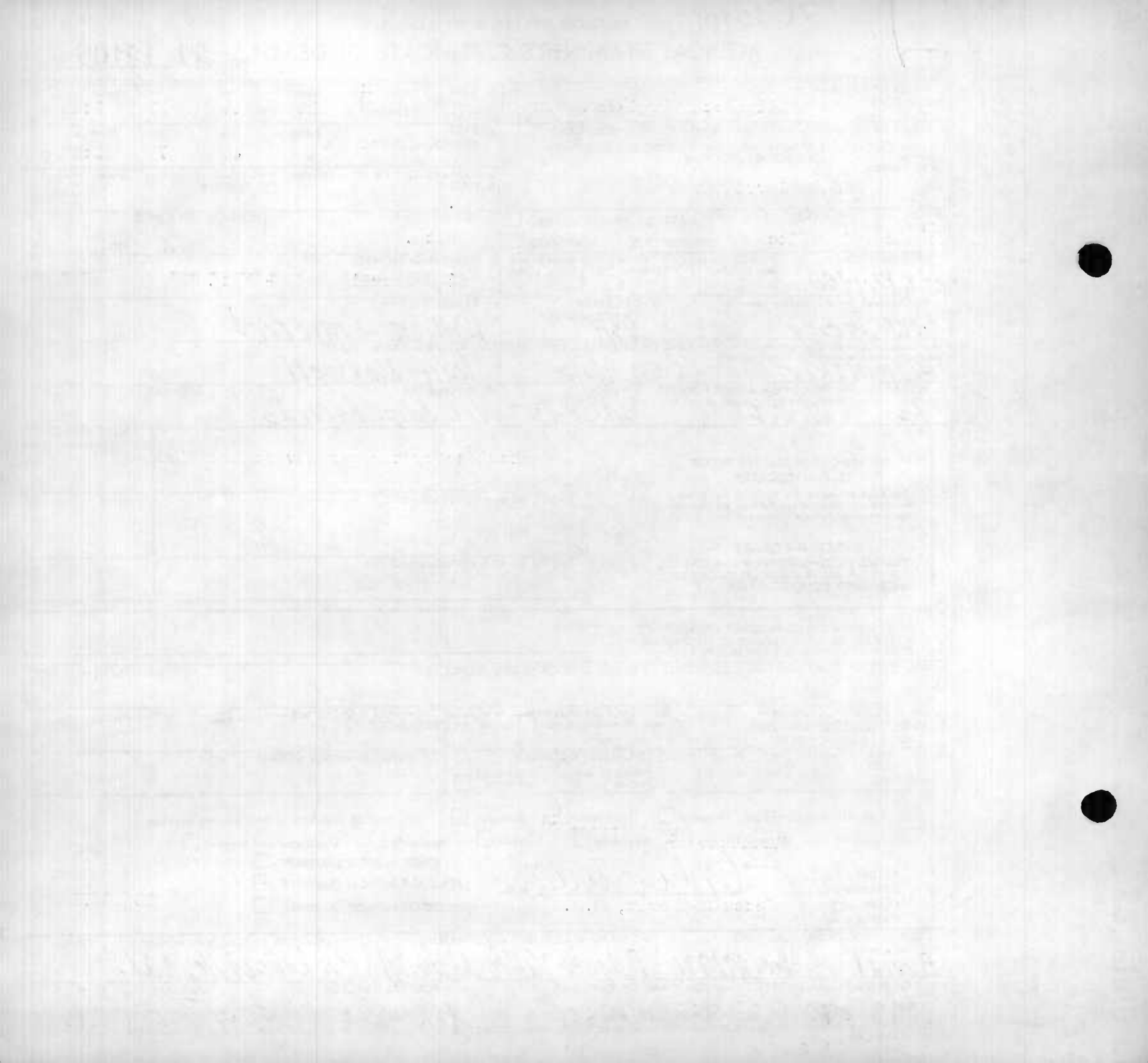
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **71 12106**

**BIRTH NO.**

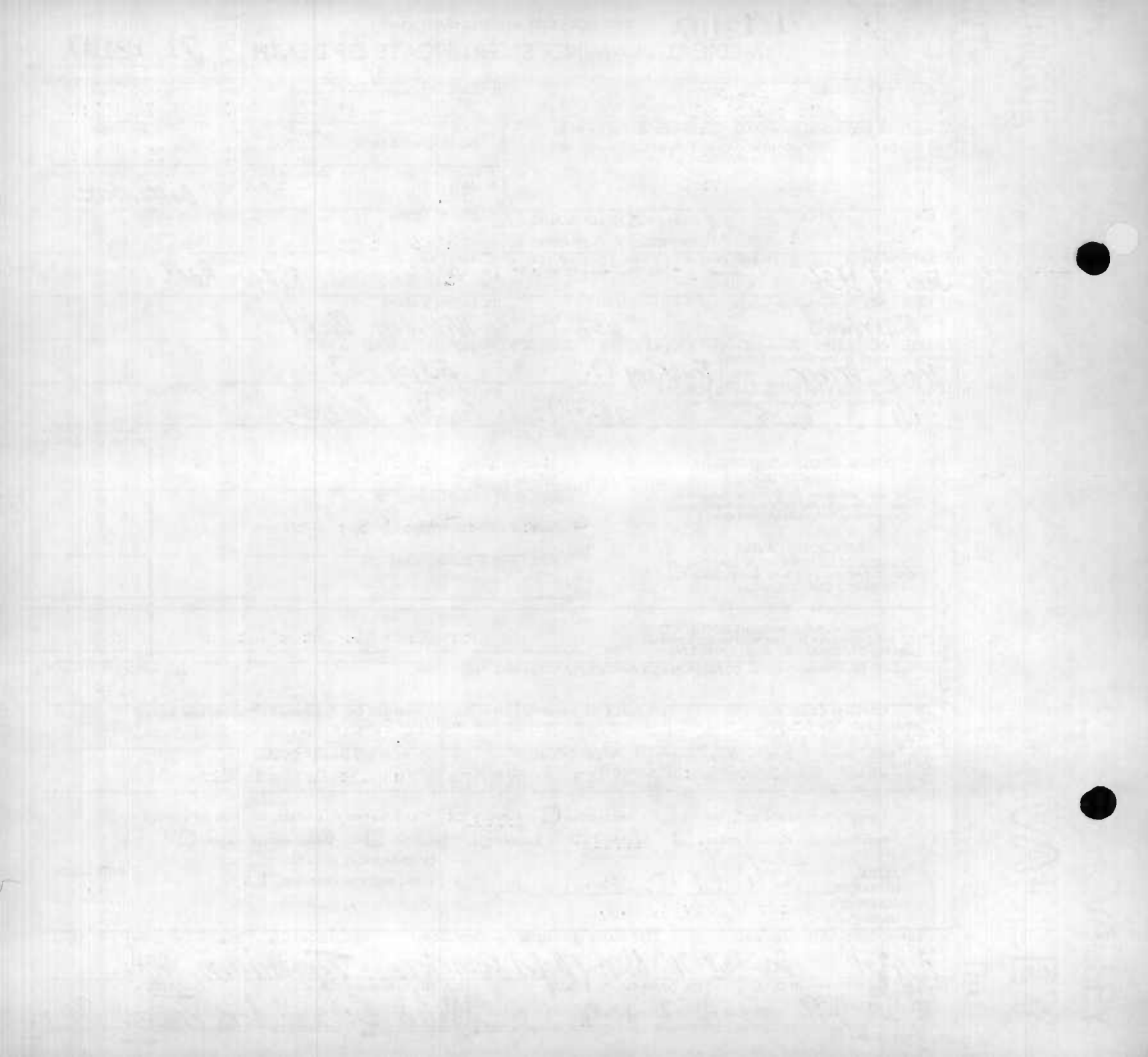
<b>1. NAME OF DECEASED</b> (Type or Print) <b>Elizabeth Virginia Jessop</b>		<b>2. DATE OF DEATH</b> Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 24 71 11:20 p.m.</b>	
<b>4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00 5409 Sarril Road</b>		<b>3. DATE PRONOUNCED DEAD</b> Month Day Year Hour <b>12 24 71 11:20 p.m.</b>	
<b>6. SEX</b> female		<b>7. RACE</b> White	
<b>8. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>5. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2644</b>	
<b>9. DATE OF BIRTH</b> <b>OCT. 17, 1900</b>		<b>10. AGE</b> (In years lost birthday) <b>71</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>New Jersey</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>14A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		<b>14B. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>	
<b>16. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.I.</b>		<b>17. SOCIAL SECURITY NO.</b> <b>212-05-9307</b>	
<b>18. INFORMANT</b> <b>Vet. Adm. Records</b>		<b>ADDRESS</b>	
<b>19. CAUSE OF DEATH</b> <b>Arteriosclerotic cardiovascular disease</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
<b>20A. DATE OF OPERATION</b> <b>0</b>		<b>20B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>	
<b>22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH?</b>		<b>22B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	
<b>22D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>22E. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
<b>22F. HOW DID INJURY OCCUR?</b>		<b>21. AUTOPSY?</b> (Yes or No) <b>no</b>	
<b>23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></b> <b>ACTUAL SIGNATURE</b> <i>Peter Lipkovic</i> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <b>Peter Lipkovic, M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>ASSOCIATE MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>Dec. 29, 1971</b>	
<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Pulasky Valley Memorial</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Cockeysville, Md.</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 3 1972</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Jaber, M.D.</b>	
<b>25C. FUNERAL DIRECTOR</b> <b>John Burns &amp; Sons, Trueman, Md.</b>		<b>ADDRESS</b>	

VS 151-REV. 1/1/68





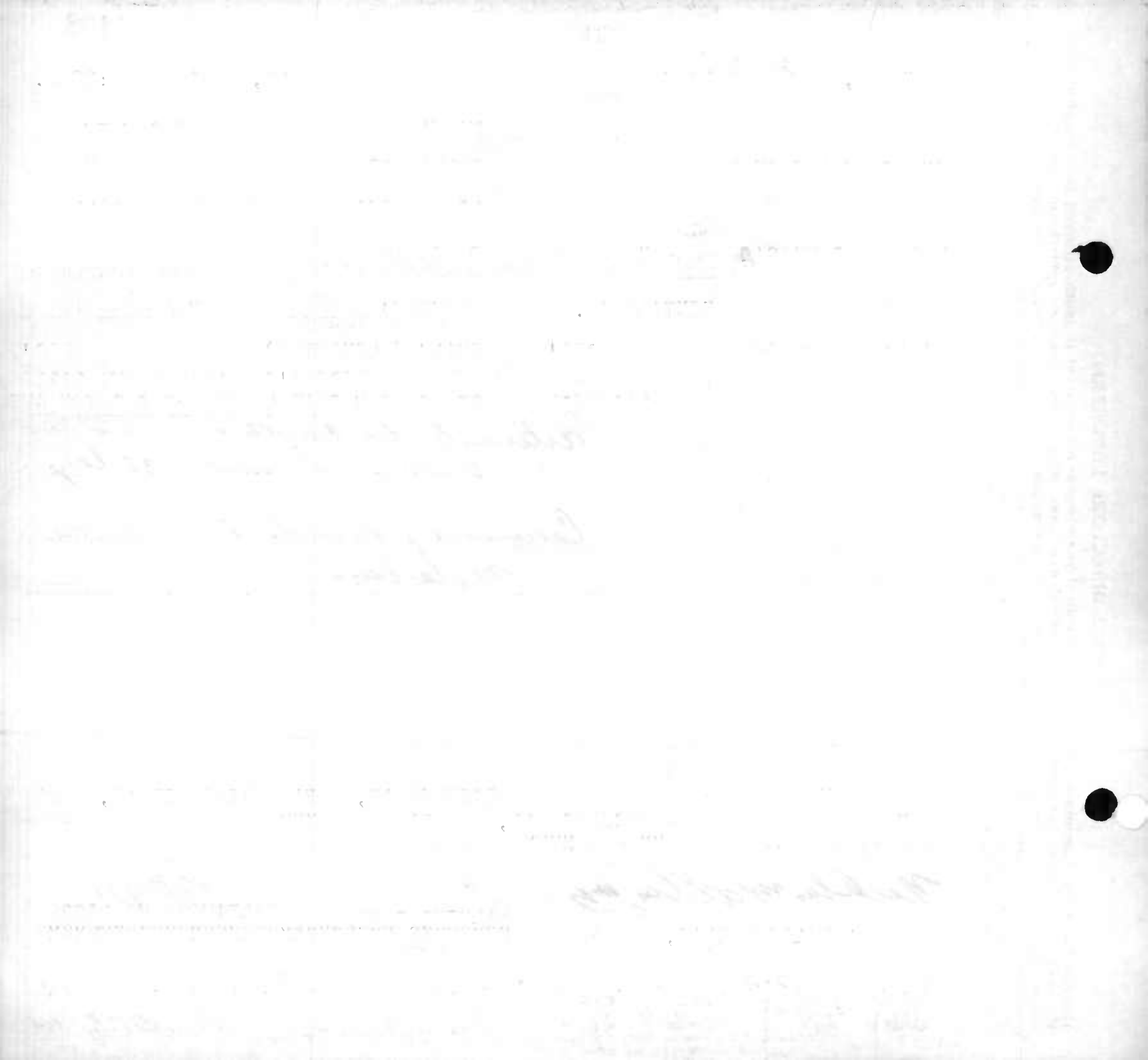
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location)		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
D-400 71 12107 LOUIS George Diehl		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 23 Year 71 Hour 11:10 P.M.		Month 12 Day 23 Year 71 Hour 11:10 P.M.		Sinai Hospital		A. STATE Md. B. COUNTY Baltimore	
6. SEX male		7. RACE White		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Reisterstown		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Jan. 29, 1936		10. AGE (In years lost birthday) 37		If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER Rt 1 Box 84A		Ridge Road	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Diehl		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		14B. KIND OF BUSINESS OR INDUSTRY Trucking Co.	
15. MOTHER'S MAIDEN NAME Edna ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-32-0059		18. INFORMANT Family Records		ADDRESS	
19. E 890 X1 + 303.7		CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Carbon monoxide poisoning		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Acute alcoholic intoxication							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Rt. 1 Box 84A		22D. TIME (Month) (Day) (Year) (Hour) (Minute) (Approx.) 12 23 71 10:30 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Subject in house fire		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/24/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 28, 1971		24C. NAME OF CEMETERY or CREMATORY Mary's Chapel Cemetery		24D. LOCATION (City, town, or county) (State) Timonium, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

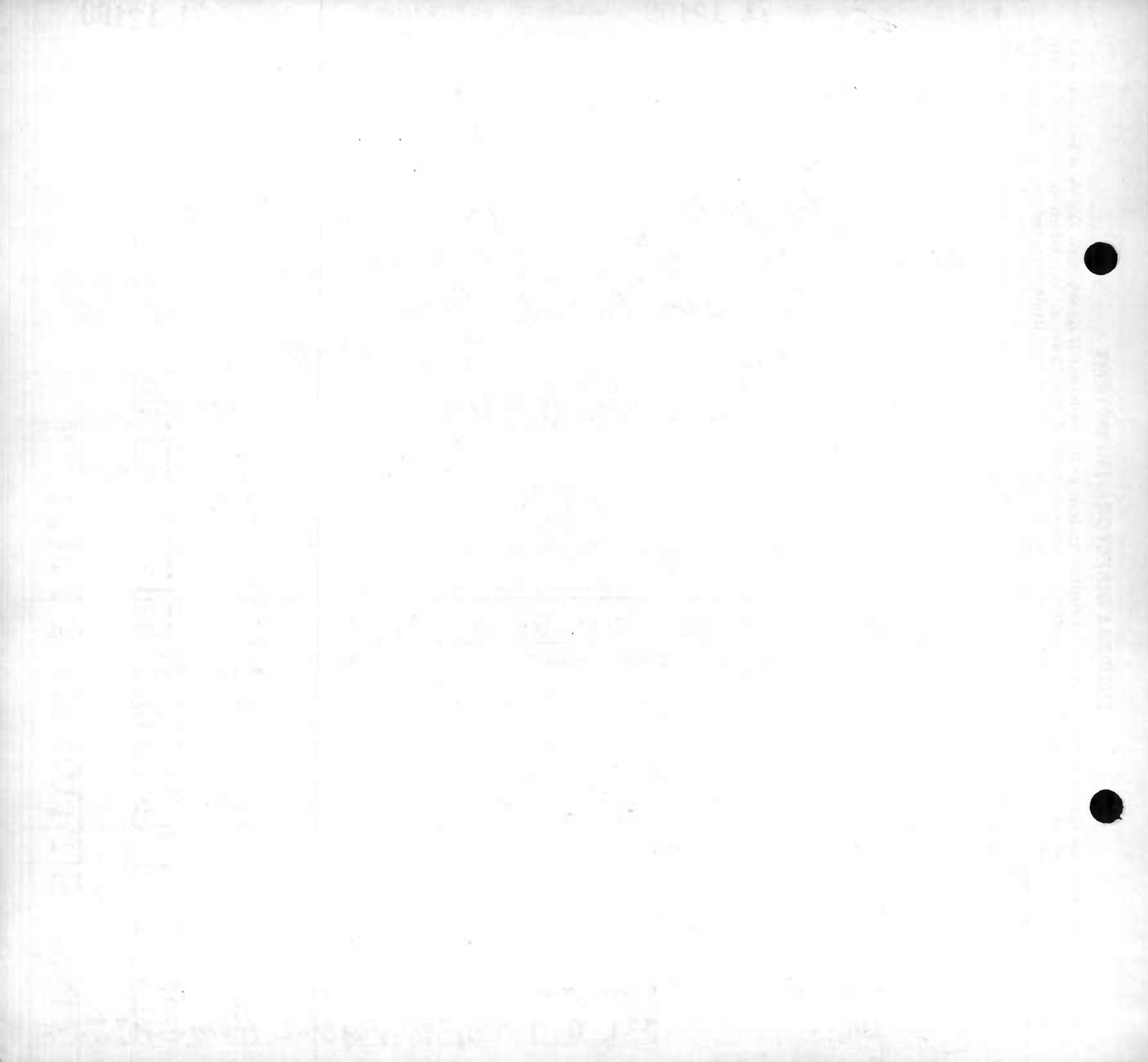
Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. <u>71 12108</u>	
BIRTH NO. <u>D-100</u>				1. NAME OF DECEASED <u>71 12108</u> (Type or Print) <u>DAYHOFF, EDWARD DORSEY</u>		2. DATE AND HOUR OF DEATH <u>DECEMBER 27, 1971</u> <u>11:20 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE COUNTY</u>		5. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>ST AGNES HOSPITAL</u> <u>40</u>				E. STREET AND NUMBER <u>2309 WESTCHESTER AVENUE</u> <u>21228</u>			
5. SEX <u>MALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06 08 92</u>	9. AGE (in years last birthday) <u>79</u>	10. Under 1 Yr. Months: Days: <u>      </u>	11. Under 24 Hrs. Hours: Min. <u>      </u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WEAVER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>TEXTILE CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>WILLIAM DAYHOFF</u> DEC 'D			14. MOTHER'S MAIDEN NAME <u>EMILY (ALEXANDER)</u> DEC 'D				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>213096370</u>		17. INFORMANT <u>RECORD'S BALTIMORE MD 21229</u> <u>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</u>		
18. <u>412.44188X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardio-</u> <u>CAUSE OF DEATH</u> (A) IMMEDIATE CAUSE <u>Vascular Stenosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Carcinoma of Bladder</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>metastases</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>16 months</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>      </u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>      </u>		20A. AUTOPSY? (Yes or No) <u>      </u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>      </u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>      </u>		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) <u>      </u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>      </u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR <u>      </u>			
22. I certify that (X) (this hospital) attended the deceased from <u>DECEMBER 17, 19 71</u> to <u>DECEMBER 27, 19 71</u> that (X) (we) last saw the deceased alive on <u>DECEMBER 27, 19 71</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE <u>Nicholas Mallis, M.D.</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12/28/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>NICHOLAS MALLIS, MD</u>				23D. ADDRESS <u>WILKENS &amp; PINE BALTIMORE MD 21229</u> <u>XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-30-71</u>		24C. NAME OF CEMETERY OR CREMATORY HGTS <u>Good ShePherd Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Ellicott City, Md 21043</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Robert E. ...</u>		ADDRESS <u>Ellicott City Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

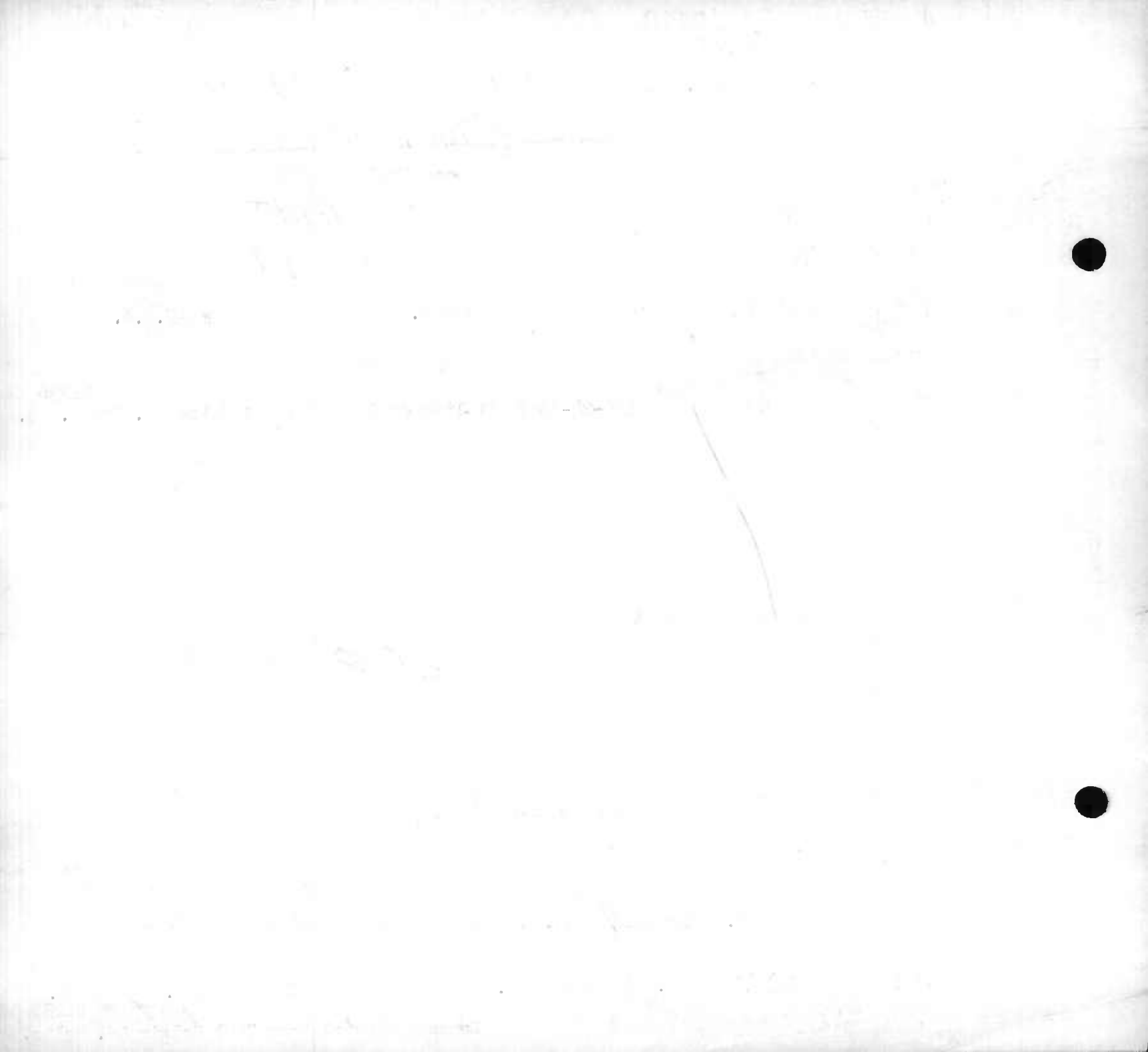
W-650 71 12109				BALTIMORE CITY HEALTH DEPARTMENT		71 12109	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
WURM Charles Joseph				12-29-71 12 noon			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
South Baltimore General Hospital 43		2505		MARYLAND		2505	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				1408 Locust Street			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		3-9-28 43	
9. AGE (In years lost birthday)				10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
43				Sears Roebuck		Penn.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				12. CITIZEN OF WHAT COUNTRY?			
Repairman				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles				Jessie Mc Mullen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				161-20-1918		Wife 1408 LOCUST ST.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE			
DUE TO, OR AS A CONSEQUENCE OF:				Acute Myocardial Infarction			
ANTECEDENT CAUSES				Arteriosclerotic Heart Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
Diabetes mellitus by History				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Diabetes mellitus by History			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		White <input type="checkbox"/> Not White <input type="checkbox"/>					
		Work <input type="checkbox"/> At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Dec 29 1971 to Dec 29 1971							
that (I) (we) lost saw the deceased alive on Dec 29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Colvin C. Carter, MD				Dec 29, 1971		Colvin C. Carter MD	
23D. ADDRESS				23E. FUNERAL DIRECTOR			
3001 S. Hanover St Balto. Md.				HARRIS FUNERAL Home			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		12-31-71		Cedar Hill		Ritchie Hwy BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 8 1972		Robert E. Taylor, M.D.		HARRIS FUNERAL Home		4200 Pennington	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 12110	
J-532 71 12110				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MARY M. Janitzky</u>		2. DATE AND HOUR OF DEATH <u>12-29-71</u> <u>1230</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hosp.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Perry Hall</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>W</u>		8. DATE OF BIRTH <u>5-29-24</u> 9. AGE (in years last birthday) <u>47</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reg. Nurse</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Harold Boughton</u>		14. MOTHER'S MAIDEN NAME <u>Mary McDonough</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>180-24-8675</u>		17. INFORMANT <u>William Janitzky</u> ADDRESS <u>4118 Kahlston Rd. Balto. Md. 21236</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>182.01</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>METASTATIC CARCINOMA OF ENDOMETRIUM</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> 19 <u>71</u> to <u>12/29</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/19 am</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and, from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Karen B. Strauss</u>		23B. DATE SIGNED <u>12-29-71</u>			
23C. PHYSICIAN'S NAME (Type) <u>Karen B. Strauss, M.D.</u>		23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/3/72</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Michaels Luth. Cemetery</u>	
24D. LOCATION <u>Perry Hall Balto. Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		25B. NAME OF REGISTRAR <u>Robert J. ...</u>		25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u> ADDRESS <u>7401 Belair Rd. Balto. 21236</u>	





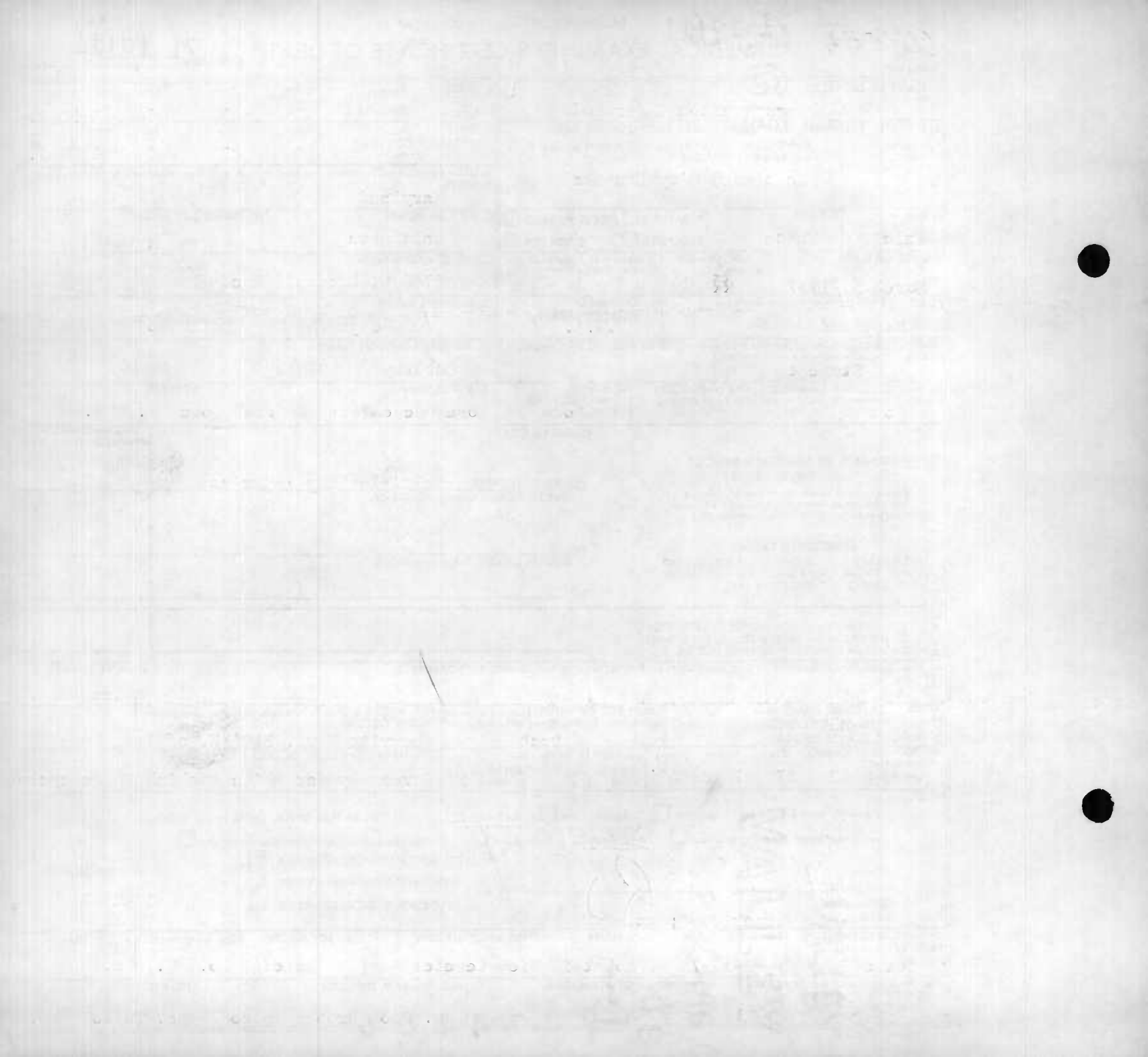
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U-536 71 12111 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH X 71 12111

BIRTH NO. \_\_\_\_\_ REG. NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) Thomas Preston Underwood		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 27 71 2:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 27 71 2:30 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH March 5, 1957		10. AGE (In years last birthday) 42 14	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		15. MOTHER'S MAIDEN NAME Dorothy Sluss	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. Unknown	
18. INFORMANT Rose & Quesenberry Funeral Home		ADDRESS W., Va.	
19. E 814.17 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Multiple body injuries DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME (Month) (Day) (Year) (Hour) (P.M.) 12 27 27 3:04 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Merritt Blvd, 310' N. of Ives Lane		22F. HOW DID INJURY OCCUR? Struck by car while pushing Honda cycle	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-28-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-71	
24C. NAME OF CEMETERY or CREMATORY Mountain View Cemetery		24D. LOCATION (City, town, or county) (State) Raleigh Co., W., Va.	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc.		ADDRESS Towson, Md.	

VS 151-REV. 1/1/68 N 869.0



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-625 71 12112		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 12112	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mrs. Clara Merson		2. DATE AND HOUR OF DEATH 12/27/71 19:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE MD. B. COUNTY CITY BALTO 5300		C. CITY OR TOWN CITY D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		E. STREET AND NUMBER 2023 Russell Ave.			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/01	9. AGE (in years last birthday) 70	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Louis Berg		14. MOTHER'S MAIDEN NAME Johanna Vogel	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-05-5261		17. INFORMANT Helena Lawrence-Old Annapolis Rd. Rt #4 Ellicott City, Maryland	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiogenic shock (B) DUE TO, OR AS A CONSEQUENCE OF: Aortic-septal MI-massive (C) ASCVD chx diaphragmatic rupture		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 12/27/71 to 12/27/71 that (1) (we) lost saw the deceased alive on 12/27/71 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George C. Samaras MD		23B. DATE SIGNED 12/27/71		23C. PHYSICIAN'S NAME (Type) George C. Samaras MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/71		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 8 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr. MD	
25C. FUNERAL DIRECTOR Armatost Funeral Chapel, 4600 Liberty Hts		25D. ADDRESS		25E. NAME OF REGISTRAR 000	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. _____	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <div style="text-align: center; font-weight: bold;">MYRTLE E. HAYNIE</div>		<b>2. DATE AND HOUR OF DEATH</b> <div style="text-align: center; font-size: 1.2em;">12/28/71 18<sup>00</sup> A</div>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <div style="text-align: center; font-weight: bold;">THE JOHNS HOPKINS HOSPITAL</div>		<b>4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)</b> A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b> <b>C. CITY OR TOWN</b> <b>BALTIMORE</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>5612 STONINGTON AVE 21207</b>			
<b>5. SEX</b> <b>FEMALE</b> <b>6. RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>03/09/27</b> <b>9. AGE (In years last birthday)</b> <b>44</b>	
<b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Computer Programmer</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>RANDOLPH HAYNIE</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>OLIVIA LEASH</b>			
<b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>219-22-4913</b>		<b>17. INFORMANT ADDRESS</b> <b>Edward Haynie-5612 Stonington Avenue #7</b>	
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <div style="text-align: center; font-weight: bold;">II</div> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> </div> <div style="width: 35%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> </div> </div> <div style="margin-top: 10px;"> <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <i>Cancer metastatic to Brain + Bone</i>  <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <i>Breast Cancer</i>  <b>(C)</b> _____                 </div>					
<b>MEDICAL CERTIFICATION</b> <b>19A. DATE OF OPERATION</b> <b>01/969</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <i>Cancer Breast</i> <b>20A. AUTOPSY? (Yes or No)</b> <i>No</i> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>NO</b>					
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b> <input type="checkbox"/>		<b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>11/25/71</i> <b>19</b> <i>to</i> <i>12/28/71</i> <b>19</b> <b>that (I) (we) last saw the deceased alive on</b> <i>12/28</i> <b>1971</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>Noble M. Hansen M.D.</i>				<b>23B. DATE SIGNED</b> <i>12/28/71</i>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>NOBLE M. HANSEN M.D.</b>				<b>23D. ADDRESS</b> <b>THE JOHNS HOPKINS HOSPITAL</b>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>12-31-71</b>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Woodlawn Cemetery</b>	
<b>24D. LOCATION (City, town, or county) (State)</b> <b>Baltimore, Maryland</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 3 1972</b> <b>25B. NAME OF REGISTRAR</b> <i>Robert E. J. J. R.D.</i> <b>25C. FUNERAL DIRECTOR ADDRESS</b> <b>Armacost Funeral Chapel-4600 Liberty Hts</b>			

1/8/81

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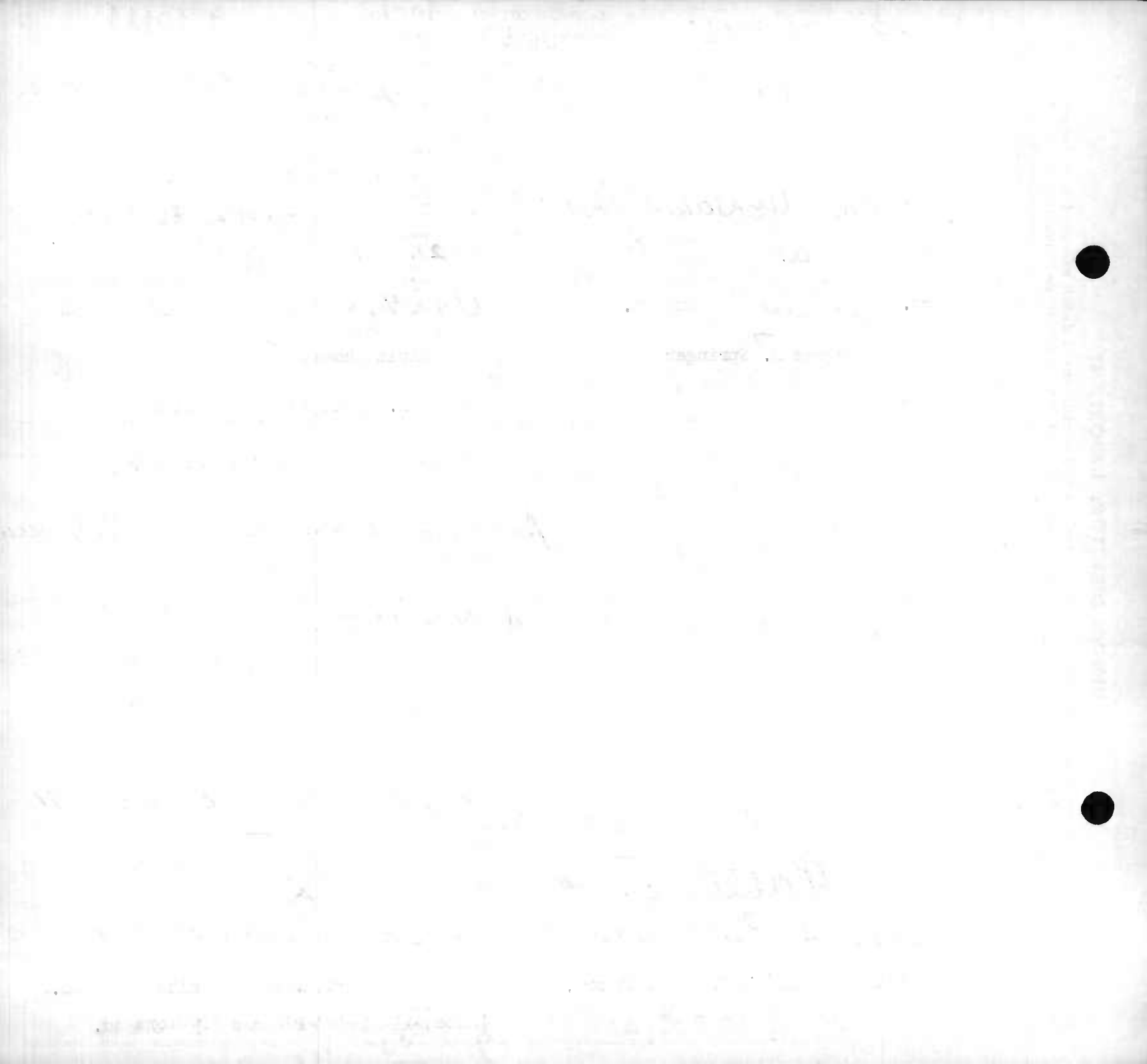
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 12114	
71 12114					
BIRTH NO. 5-165					
1. NAME OF DECEASED (Type or Print) SPRINGER, GEORGE E.					
2. DATE AND HOUR OF DEATH			12-23-1971 11:20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE B. COUNTY		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
UNION MEMORIAL HOSPITAL			MD BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			422 - ROSEBANK AV. BALTO 21212		
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M W		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
June 29, 1889		82?		Retired.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
MARYLAND		U.S.A.		Eugene R. Springer	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Elvia Thomas		No		George L. Springer	
17. INFORMANT		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Same		4/10/71 I		Myocardial Infarction	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
Alterio Sclerotic - Cardio V. Disease		II		A N E M I A -	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
1 Month (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12-15-1971 to 12-23-1971 that (I) (we) last saw the deceased alive on 12-23-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
A. Battilana MD				12-23-1971	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
A. Battilana MD				UNION MEMORIAL HOSPITAL MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		12/31/71		Baltimore,	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
North Ave Balto Md.		JAN 8 1972		Robert E. Taylor MD	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. FUNERAL DIRECTOR	
Mitchell Wiedefeld Home		6500 York Rd.			

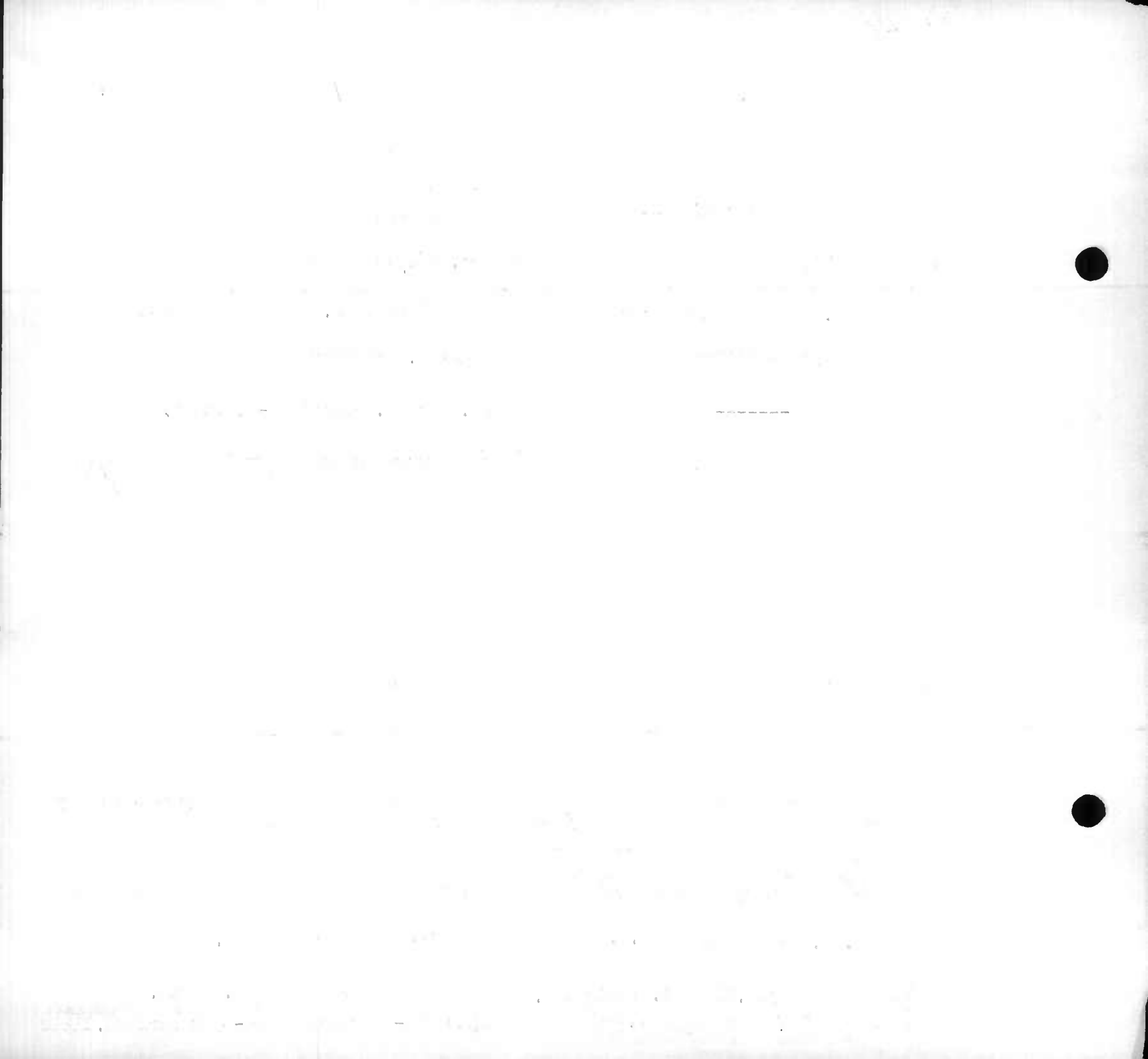




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

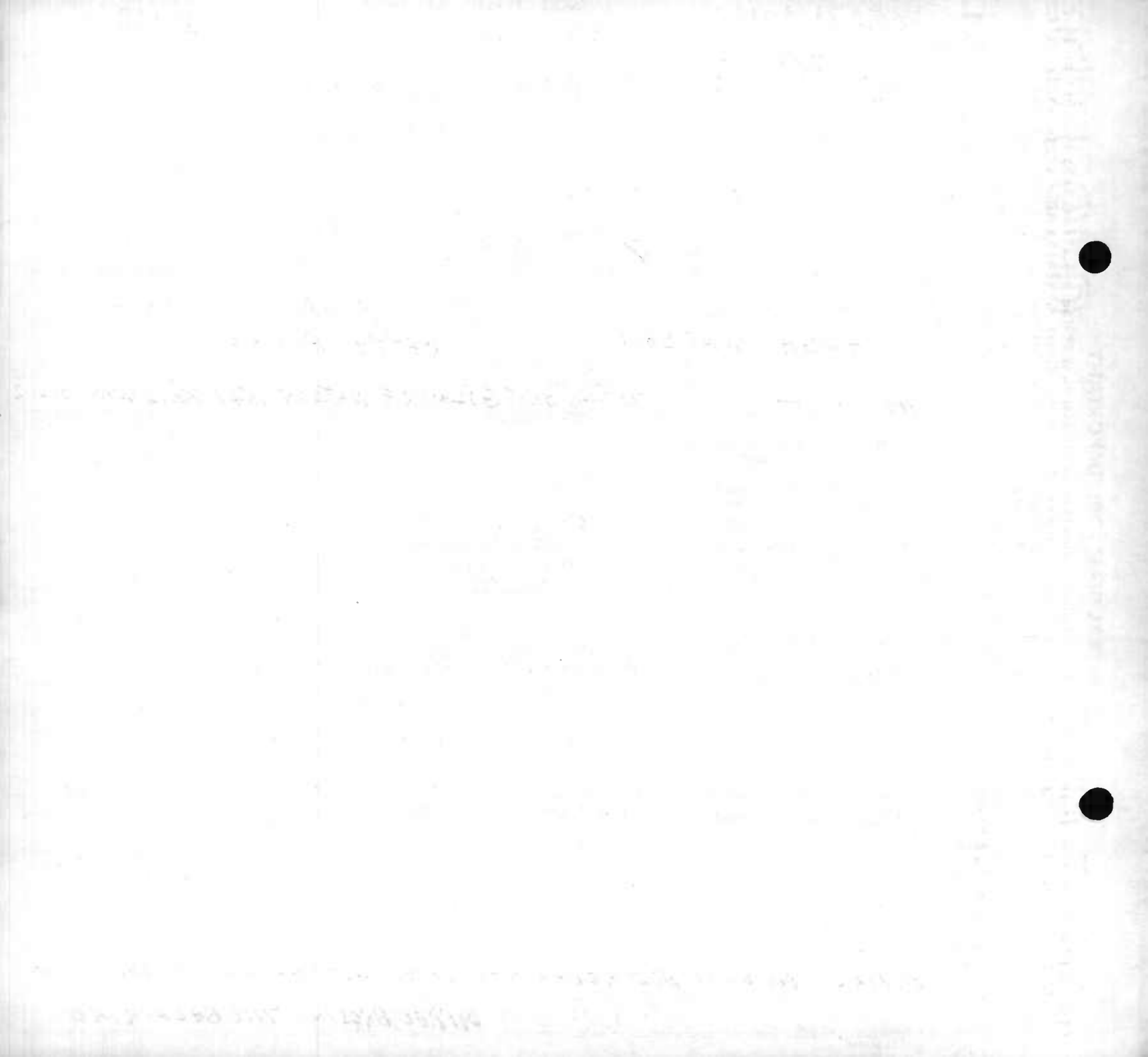
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12115</u>	
C-462 <u>71 12115</u>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>EDNA G. CLARK</u>		2. DATE AND HOUR OF DEATH <u>12/27/71</u> <u>9:30 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>1310 Cedarcroft Road</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2738</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1310 Cedarcroft Road</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1920</u>	9. AGE (In years last birthday) <u>51</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Legal Sec'y.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Law Firm</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Albert Schneider</u>			
14. MOTHER'S MAIDEN NAME <u>Anna M. Hemmeter</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mrs. Anna M. Schneider- (Mother)</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Breast</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Breast</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>Jan '69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma Breast</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>December 1971</u> that (I) (we) last saw the deceased alive on <u>Dec 17 1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. F. Palmisano M.D.</u>		23B. DATE SIGNED <u>12-28-71</u>		23C. PHYSICIAN'S NAME (Type) <u>Jos. F. Palmisano M.D.</u>	
23D. ADDRESS <u>6608 Loch Raven Blvd.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>12/29/71</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Paul's Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Druid Hill Pk. Balto.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home-6500 York Rd. 21212</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-65271 12116				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12116	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ERYING (OR) MARGARET</b>				2. DATE AND HOUR OF DEATH <b>12/26/71 110<sup>00</sup> P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>401</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY HOSPITAL 301 ST PAUL PLACE</b>				E. STREET AND NUMBER <b>1201-2 CHARLES CENTER</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/25/04</b>	9. AGE (in years last birthday) <b>67</b>	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HUGH WATSON</b>				14. MOTHER'S MAIDEN NAME <b>BETTY BURKE</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-46-0295</b>		17. INFORMANT ADDRESS <b>GILMORE WATSON 1541 KING WAY 51212</b>			
18. <b>397.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>arrest</b> <b>cardiorespiratory</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Congestive Heart Failure</b>		<b>2 weeks</b>			
				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Phenemetic Valvular Disease</b>		<b>?</b>			
				(C) <b>Embolism/occlusion Peripheral Vascular Disease</b>		<b>15 yrs</b>			
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Peripheral Vascular Disease</b>									
19A. DATE OF OPERATION <b>12/26/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Peripheral Phlebectomy</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>11/27</b> 19 <b>71</b> to <b>12/26</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12/26</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Remo S. Remo, M.D.</b>				23B. DATE SIGNED <b>12/26/71</b>		23C. PHYSICIAN'S NAME (Type) <b>E. S. REMO</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>DEC 29-71</b>		24C. NAME of CEMETERY or CREMATORY <b>HOLY REDEEMER CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>4430 BELAIR RD BALTO MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>RECEIVED</b>		25C. FUNERAL DIRECTOR <b>APRIL BRISINC</b>		ADDRESS <b>7110 BELAIR RD</b>			

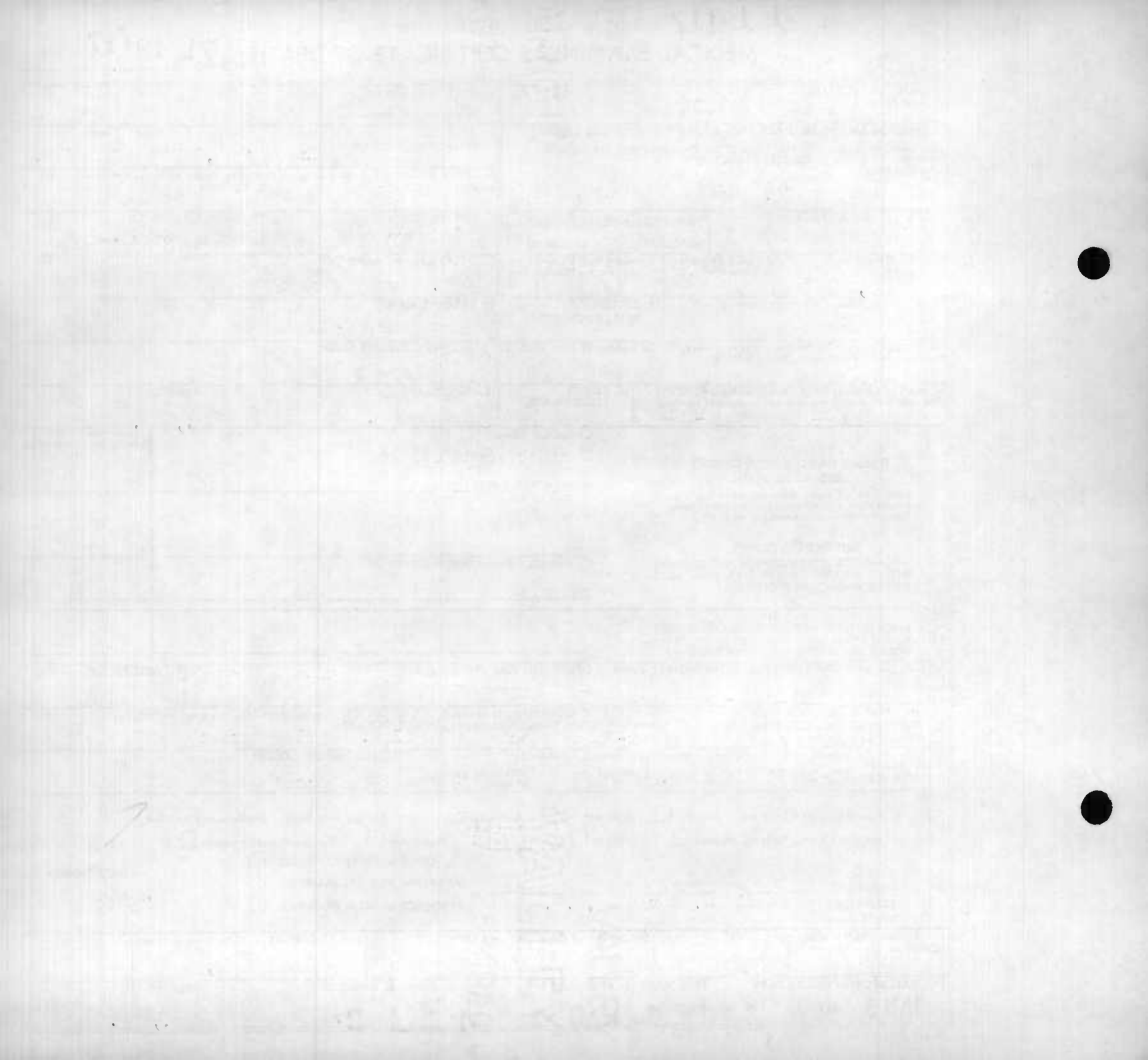


W-325 71 12117  
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 71 12117  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ELMER WATKINS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTO. GENERAL HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 28, 1971 10:55 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>March 5, 1925</b>		10. AGE (In years last birthday) <b>46</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Owner</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1-19-46 to 8-29-46</b>		17. SOCIAL SECURITY NO. <b>276 22 1404</b>	
15. MOTHER'S MAIDEN NAME <b>Calidonia Bentley</b>		18. INFORMANT <b>Dolores D. Watkins</b>	
19. <b>E 955 IX</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Gunshot wound of head</b>  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Bar-Phone Booth</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>8 37 S. Charles Street</b>		22F. HOW DID INJURY OCCUR? <b>Self-inflicted</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>12-28-71 10:25 P.m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/29/71</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-31-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>	
25C. FUNERAL DIRECTOR <b>McGully Funeral Home</b>		ADDRESS <b>130 East Fort Avenue Balto., Md. 21230</b>	

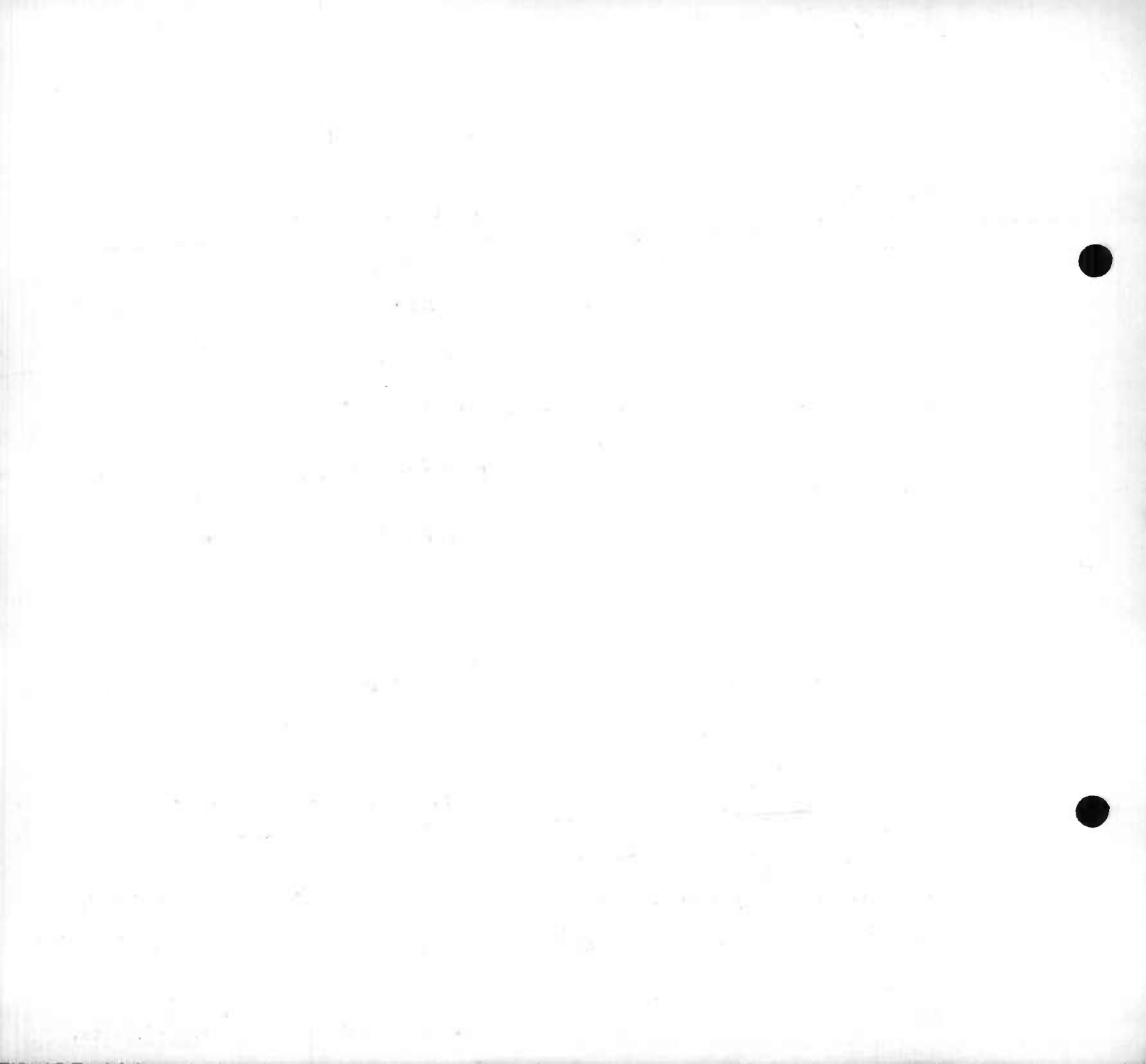
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N 854.1



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 12118</b>
BIRTH NO. <b>B-624 71 12118</b>		1. NAME OF DECEASED (Type or Print) <b>Edith E. Bragel</b>		
2. DATE AND HOUR OF DEATH <b>12-29-71 5:05 P.M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Md. Gen. Hosp Balto. Md.</b>		A. STATE <b>Md</b> B. COUNTY <b>1</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-31-04</b> 9. AGE (in years last birthday) <b>67</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HW</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Wilbur T. Hartley</b>		14. MOTHER'S MAIDEN NAME <b>Emily J. Penn</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-62-6505</b> 17. INFORMANT <b>Hosp. Chart</b> ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>162.1 I</b>		CAUSE OF DEATH <b>(A) Metastatic Oat Cell Carcinoma</b> <b>(B) Severe ASCVD grade T-4</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 Mo.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>11-27 19 71</b> to <b>12-29 19 71</b> that (I) <b>(we)</b> last saw the deceased alive on <b>12-29 19 71</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> <b>(did)</b> view the body after death.				
23A. SIGNATURE <b>Arnold G. Alexander MD</b>		23B. DATE SIGNED <b>12-29-71</b>		23C. PHYSICIAN'S NAME (Type)
23D. ADDRESS <b>827 Linden Ave Balto. Md.</b>		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12/31/71</b>		
24C. NAME of CEMETERY or CREMATORY <b>Friends Burial Ground</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor MD</b>		
25C. FUNERAL DIRECTOR <b>Seitz Funeral Home</b>		25D. ADDRESS <b>5209 York Rd. Balto.</b>		

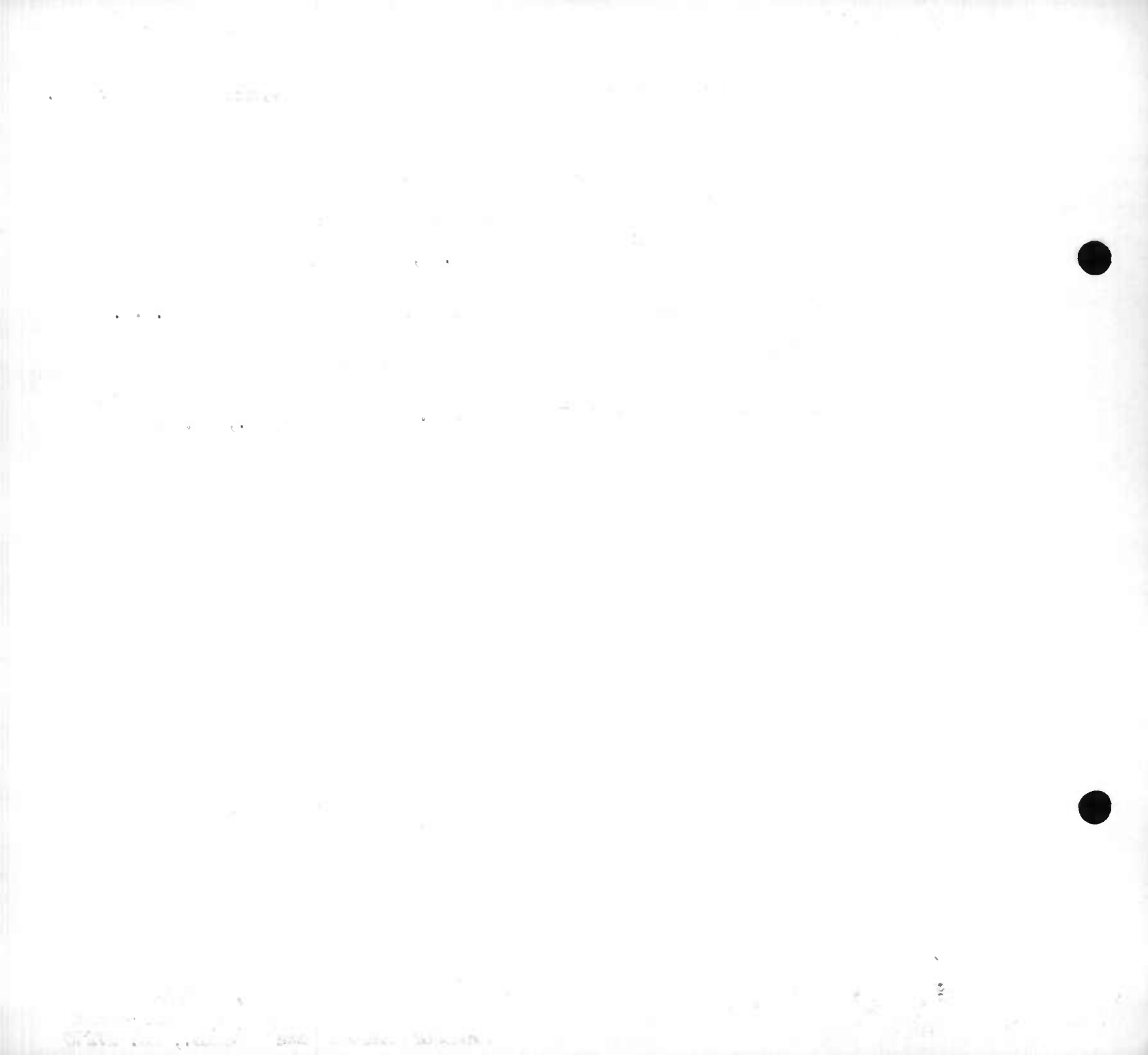




# FUNERAL DIRECTOR: IMPORTANT

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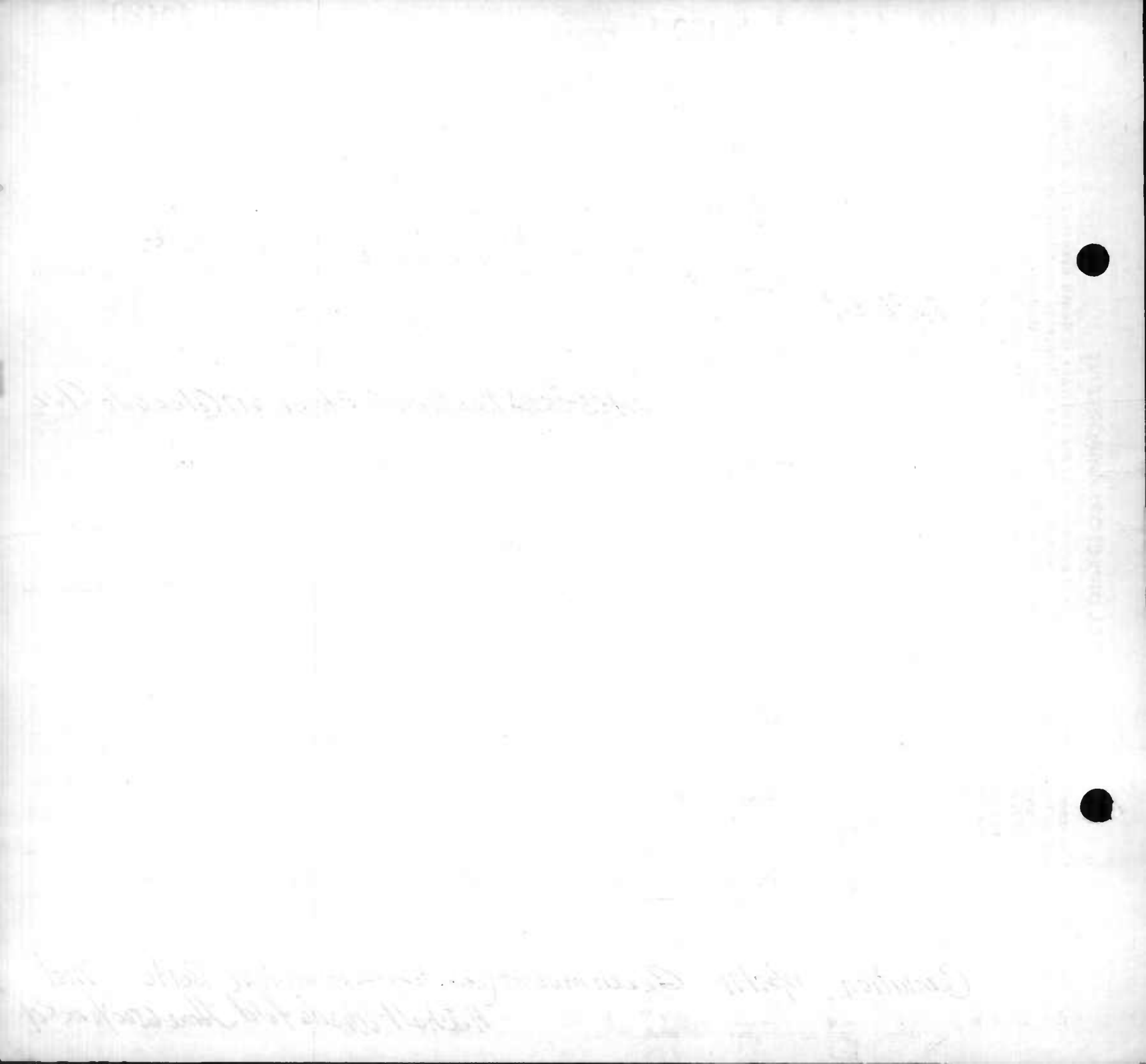
N-635 71 12119		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12119	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Charles Norton</i>		2. DATE AND HOUR OF DEATH <i>December 27, 1971 10:35 P. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2403</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Harbor View Nursing Home 1213 Light Street</i>		E. STREET AND NUMBER <i>1120 Battery Avenue</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 22, 1893</i>	9. AGE (In years lost day) <i>78 78</i>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ship yard worker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Thomas Norton</i>		14. MOTHER'S MAIDEN NAME <i>Mary McMan</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-01-3221</i>		17. INFORMANT <i>Marie C. Norton</i> ADDRESS <i>1120 Battery Avenue Balto., Md. 21230</i>	
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Ischemia</i> (B) <i>Advanced ASCVD</i> (C) <i>Anemia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Weeks</i> <i>Years</i> <i>Years</i>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <i>December 16</i> 19 <i>71</i> to <i>December 27</i> 19 <i>71</i> that (H) (we) last saw the deceased alive on <i>December 27</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Peter H. Rheinstein, MD</i>				23B. DATE SIGNED <i>Dec 28, 1971</i>	
23C. PHYSICIAN'S NAME (Type) <i>PETER H. RHEINSTEIN, MD</i>		23D. ADDRESS <i>HARBOR VIEW NURSING HOME</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-30-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial Gardens</i>	
24D. LOCATION <i>Glen Burnie, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1972</i>			
25B. NAME OF REGISTRAR <i>Reg. 3227</i>		25C. FUNERAL DIRECTOR <i>McGully Funeral Home</i>		25D. ADDRESS <i>130 East Fort Avenue Balto., Md. 21230</i>	



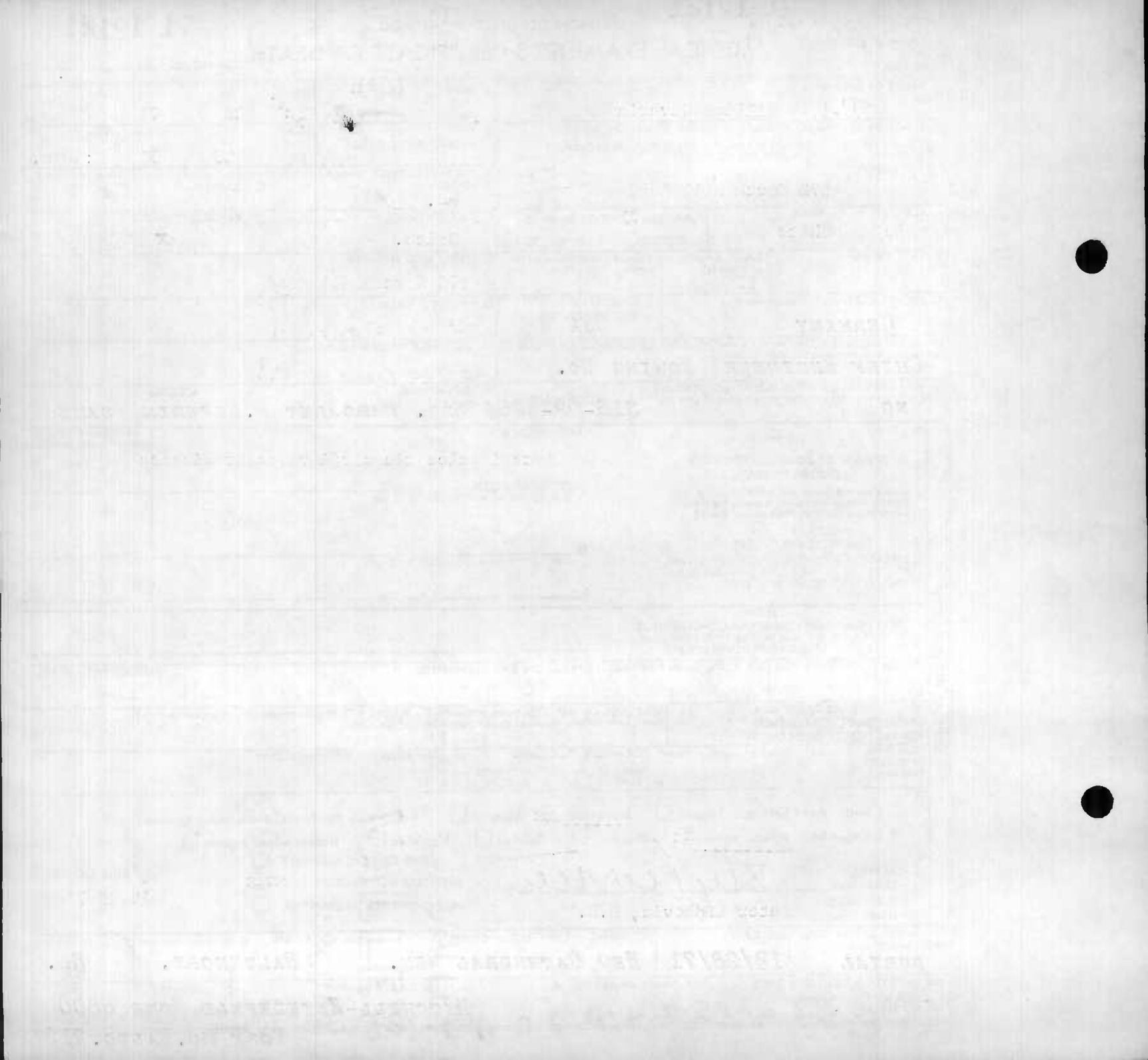
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 12120</u>	
BIRTH NO. <u>M-460 71 12120</u>				1. NAME OF DECEASED (Type or Print) <u>GARNETT R. Miller</u>		2. DATE AND HOUR OF DEATH <u>12-22-71</u> <u>8<sup>10</sup></u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Baltimore</u> B. COUNTY <u>2713</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION Memorial Hospital</u>		(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>617 Colorado Avenue</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>04-24-95</u>	9. AGE (in years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>THOMPSON J. Miller</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE O'NEAL</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-03-0539A</u>		17. INFORMANT <u>Miss Ann O. Blome 617 Colorado Ave</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>congestive heart failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-17-71</u> 19 to <u>12-22-71</u> 19 that (I) (we) last saw the deceased alive on <u>12-22-71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u> M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-22-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JAIRO RAMIREZ</u> M.D. DEGREE				23D. ADDRESS <u>UNION Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>12/27/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Greenmount Ave Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>600 York Rd</u>	



BALTIMORE CITY HEALTH DEPARTMENT				71 12121			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. _____			
BIRTH NO. _____							
1. NAME OF DECEASED (Type or Print) <u>P.J. William Severin</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month <u>12</u> Day <u>25</u> Year <u>71</u>		Hour <u>M.</u>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>972 North Hill Road</u>		3. DATE PRONOUNCED DEAD Month <u>12</u> Day <u>25</u> Year <u>71</u>		Hour <u>2:40 a.m.</u>			
6. SEX <u>male</u>		7. RACE <u>White</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u>	
9. DATE OF BIRTH <u>73</u>		10. AGE (In years last birthday) <u>73</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY SEVERIN</u>		14. MOTHER'S MAIDEN NAME <u>ERNESTINE (?)</u>		15. STREET AND NUMBER <u>972 North Hill Road</u>		16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
17. SOCIAL SECURITY NO. <u>215-09-8964</u>		18. INFORMANT <u>MRS. MARGARET F. SEVERIN</u>		19. ADDRESS <u>SAME</u>			
19. <u>412.41</u>		CAUSE OF DEATH <u>Arteriosclerotic cardiovascular disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION <u>0</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>no</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <u>Peter Lipkovic, M.D.</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/25/71</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/28/71</u>		24C. NAME of CEMETERY or CREMATORY <u>NEW CATHEDRAL CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fabel, M.D.</u>		25C. FUNERAL DIRECTOR <u>MITCHELL-WIEDEFELD HOME</u>		ADDRESS <u>6500 YORK RD. BALTO. 21212</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12122</b>	
H-416 71 12122		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HALBERT, NORMA V</b>		2. DATE AND HOUR OF DEATH <b>Dec 24, 1971 11:15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>		2303	
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL BALTIMORE</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>1828 S. CHARLES ST.</b>			
5. SEX <b>F</b>	6. RACE <b>C W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 6 1904</b>	9. AGE (In years last birthday) <b>67</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Hopkins Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Balto Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles Tommolan</b>		14. MOTHER'S MAIDEN NAME <b>Florence Jory</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214 036030</b>		17. INFORMANT <b>LaVern Hampton</b> ADDRESS <b>105 Condon Ave Glen Burnie Md</b>	
18. <b>571.7 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>HEPATIC COMA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ADVANCE POST-HEPATIC CIRRHOSIS</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(s)</del> (this hospital) attended the deceased from <b>DEC. 2</b> 19 <b>71</b> to <b>DEC. 27</b> 19 <b>71</b> that <del>(s)</del> (we) last saw the deceased alive on <b>DEC. 27</b> 19 <b>71</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(s)</del> (We) (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Armando C. Dinamco, M.D.</b>		23B. DATE SIGNED <b>Dec. 27, 1971</b>		23C. PHYSICIAN'S NAME (Type) <b>ARMANDO C. DINAMCO, M.D.</b>	
23D. ADDRESS <b>SINAI HOSP. BALTIMORE, MD.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/71</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>2930 Fredrick Ave</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>	
25B. NAME OF REGISTRAR <b>Rebecca J. ...</b>		25C. FUNERAL DIRECTOR <b>Moody Funeral Home</b>		25D. ADDRESS <b>237 Patapsco Ave 21225</b>	

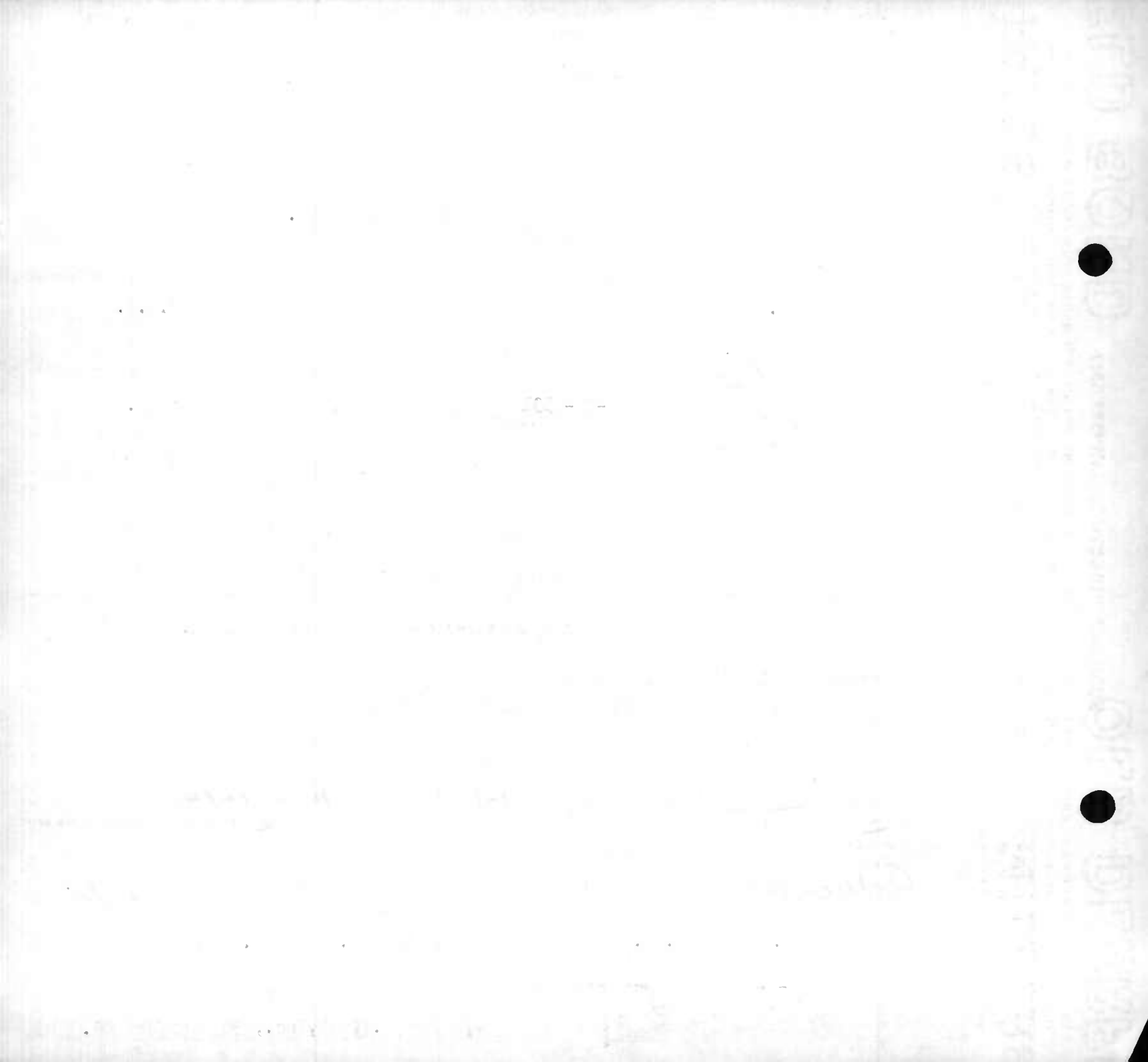




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

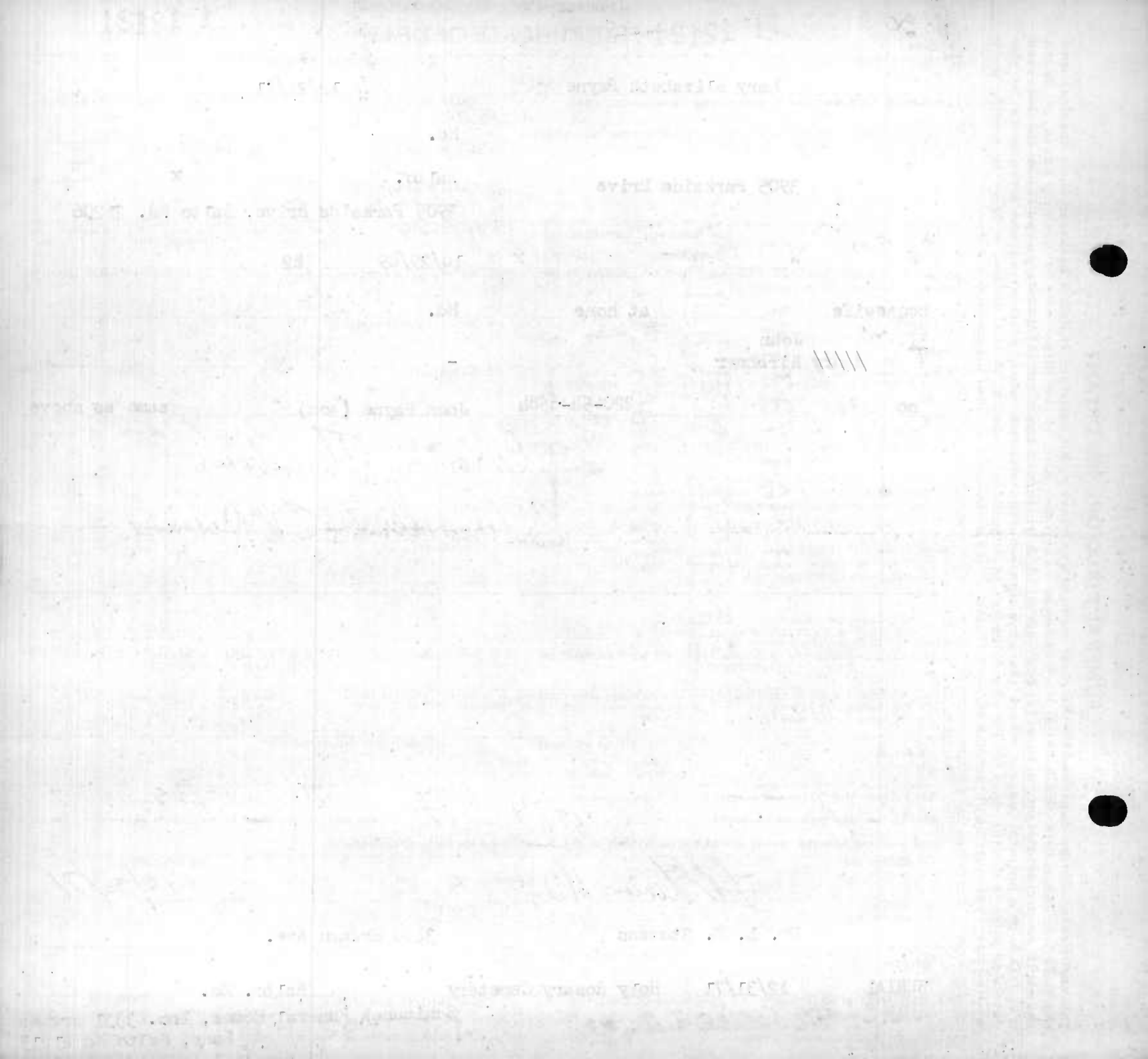
BIRTH NO. <b>M-625 71 12123</b>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <b>71 12123</b>	
1. NAME OF DECEASED (Type or Print) <b>MORGAN</b>		ANNE MARY AGNES		2. DATE AND HOUR OF DEATH <b>12/30/71</b>		<b>4:20 A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>MERCY HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2633</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MERCY HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>3303 Ramona Ave.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/14/83</b>	9. AGE (In years last birthday) <b>88</b>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary Ret.</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James Francis Morgan</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Caffrey</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-05-1331</b>		17. INFORMANT <b>Madeline Klein, 5715 Benton Hghts.</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Cardio respiratory arrest</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Myocardial Infarction</b> <b>(C) Longtime Heart Failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> <b>23 days</b> <b>6 Months</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b> <b>Arteriosclerotic Cardiovascular Disease</b>							
19A. DATE OF OPERATION <b>1/2/78/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Remnant Pilonidal</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/67</b> <b>1971</b> to <b>12/30</b> <b>1971</b> that (I) (we) last saw the deceased alive on <b>12/30</b> <b>1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Eduardo S. Remo M.D.</b>				23B. DATE SIGNED <b>12/30/71</b>		23C. PHYSICIAN'S NAME (Type) <b>EDUARDO S. REMO, M. D.</b>	
23D. ADDRESS <b>MERCY HOSPITAL</b> <b>301 St. Paul Pl.</b>		23E. ADDRESS <b>301 St. Paul Pl.</b>		23F. ADDRESS <b>301 St. Paul Pl.</b>		23G. ADDRESS <b>301 St. Paul Pl.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-3-72</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Buck, Inc.</b>		ADDRESS <b>5305 Harford Rd.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

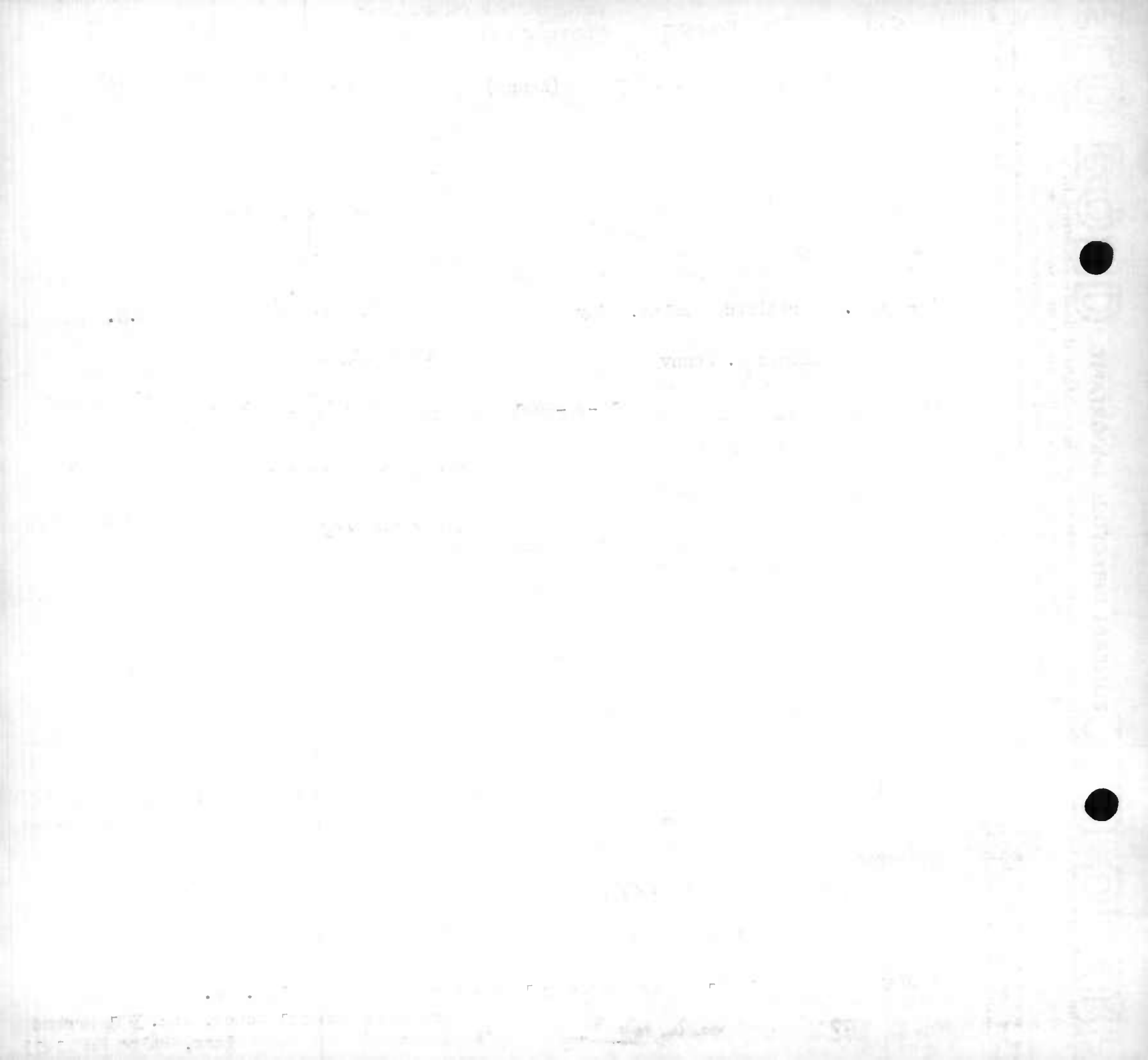
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12124</b>	
BIRTH NO. <b>P-500</b>		71 12124		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>Mary Elizabeth Payne</b>			2. DATE AND HOUR OF DEATH <b>12/28/71</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3905 Parkside Drive</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2731</b>		
			C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3905 Parkside Drive, Balto Md. 21206</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10/29/89</b>	9. AGE (in years last birthday) <b>82</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>John Henry Kirchner</b>			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-54-6584</b>		17. INFORMANT <b>John Payne (son)</b>	
				ADDRESS <b>same as above</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>4/10/91</b> <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic C-V Disease</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1/28</b> 19 <b>71</b> to <b>12/28</b> 19 <b>71</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>12/1</b> 19 <b>71</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Dr. L. B. Stevens</b>				23B. DATE SIGNED <b>12/30/71</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>3400 Erdman Ave.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12/31/71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>					
25A. DATE RECD BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto Md 21213</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

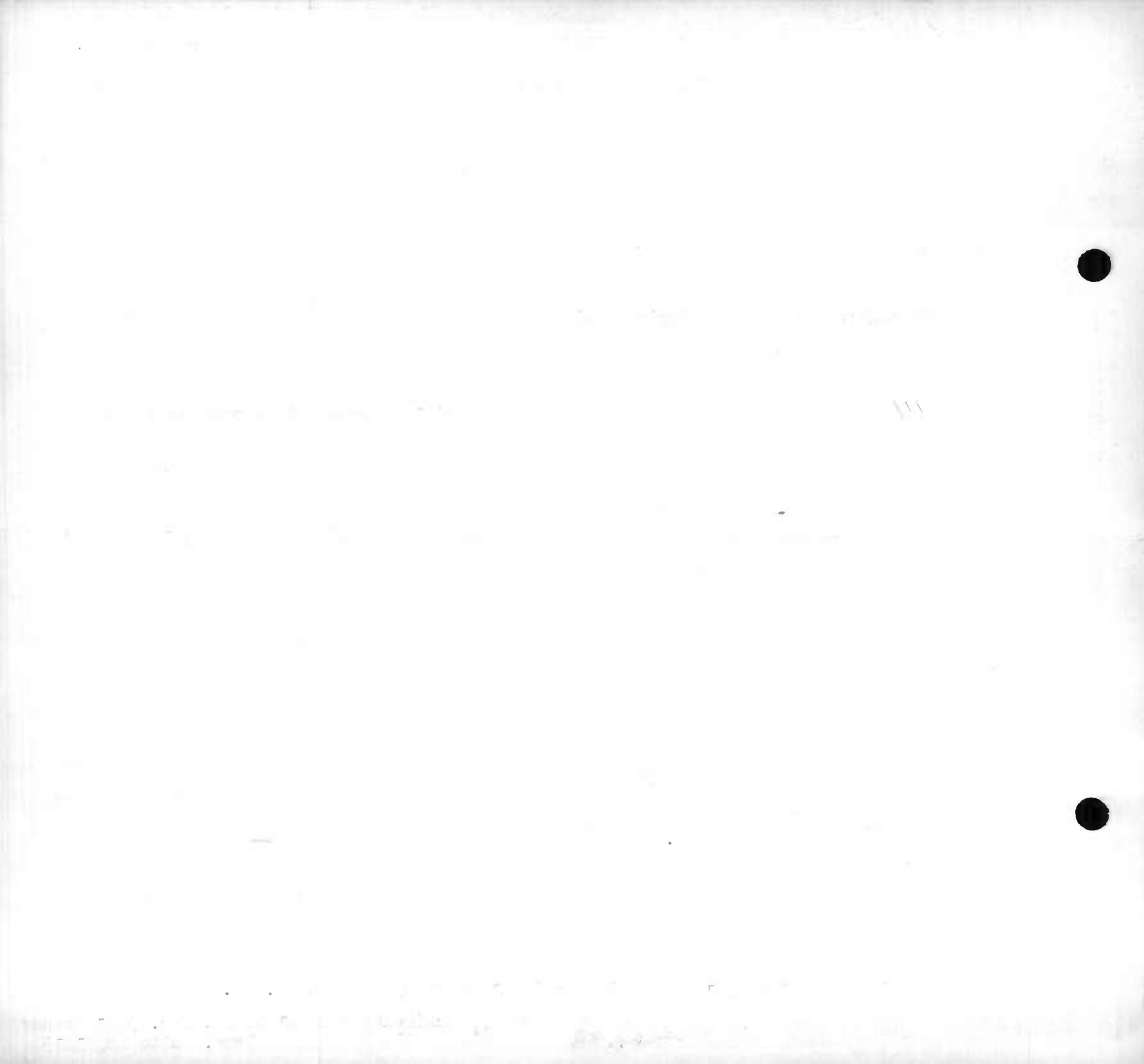
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12125</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>K-500</b></span> <span><b>71 12125</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JAMES KENNEY (Kenny)</b>		2. DATE AND HOUR OF DEATH <b>DEC 27 1971 8:52 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>BALT</b> B. COUNTY <b>841</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL</b>		C. CITY OR TOWN <b>BALT</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>3107 MARECO RD</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-22-01</b>	9. AGE (In years last birthday) <b>70</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fire Dept RET retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Thomas J. Kenny</b>		14. MOTHER'S MAIDEN NAME <b>Annie Diggs</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-28-9621</b>		17. INFORMANT ADDRESS <b>WIFE EFFIE L KENNEY SAME</b>	
18. <b>492X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>EMPHYSEMA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>4 YEARS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-27 1971</b> to <b>12 27 1971</b> that (I) (we) last saw the deceased alive on <b>12-27 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Francis X Carmody</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12-27-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRANCIS X CARMODY</b>		23D. ADDRESS <b>3201 N CHARLES</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/30/71</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION <b>Balto. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Kelly</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Homes, Inc.</b>	
25D. ADDRESS <b>331 Bröhms Lane, Balto Md 21213</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-650 71 12126		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12126	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PERRON, THEODORE PHILIAS</b>		2. DATE AND HOUR OF DEATH <b>12/27/71 4:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		2643	
FULL NAME OF HOSPITAL OR INSTITUTION <b>North Charles General Hosp</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>3910 Erdman Avenue</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-30-08</b>	9. AGE (in years last birthday) <b>63</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photographer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Harris &amp; Ewing</b>		11. BIRTHPLACE (State or foreign country) <b>Rhode Island</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>PHILIAS PERRON</b>		14. MOTHER'S MAIDEN NAME <b>EMMA FREMONT</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>030-09-2238</b>		17. INFORMANT ADDRESS <b>Lucille Perron (wife) same as above</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>569.414 250.9</b> <b>Peritonitis</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Perforated bowel</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Perforated bowel</b>		<b>4-5 days</b>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Cerebro-vascular Accident; Diabetes Mellitus</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/23</b> 19 <b>71</b> to <b>12/27</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12/27</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rufino G. Montenegro M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/27/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>RUFINO G. MONTENEGRO M.D.</b>		23D. ADDRESS <b>2924 North Charles, Balto. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/30/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Bohemian National Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Rub E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>Schmunek Funeral Homes, Inc. 3331 Brehms Lane, Balto Md 21213</b>	

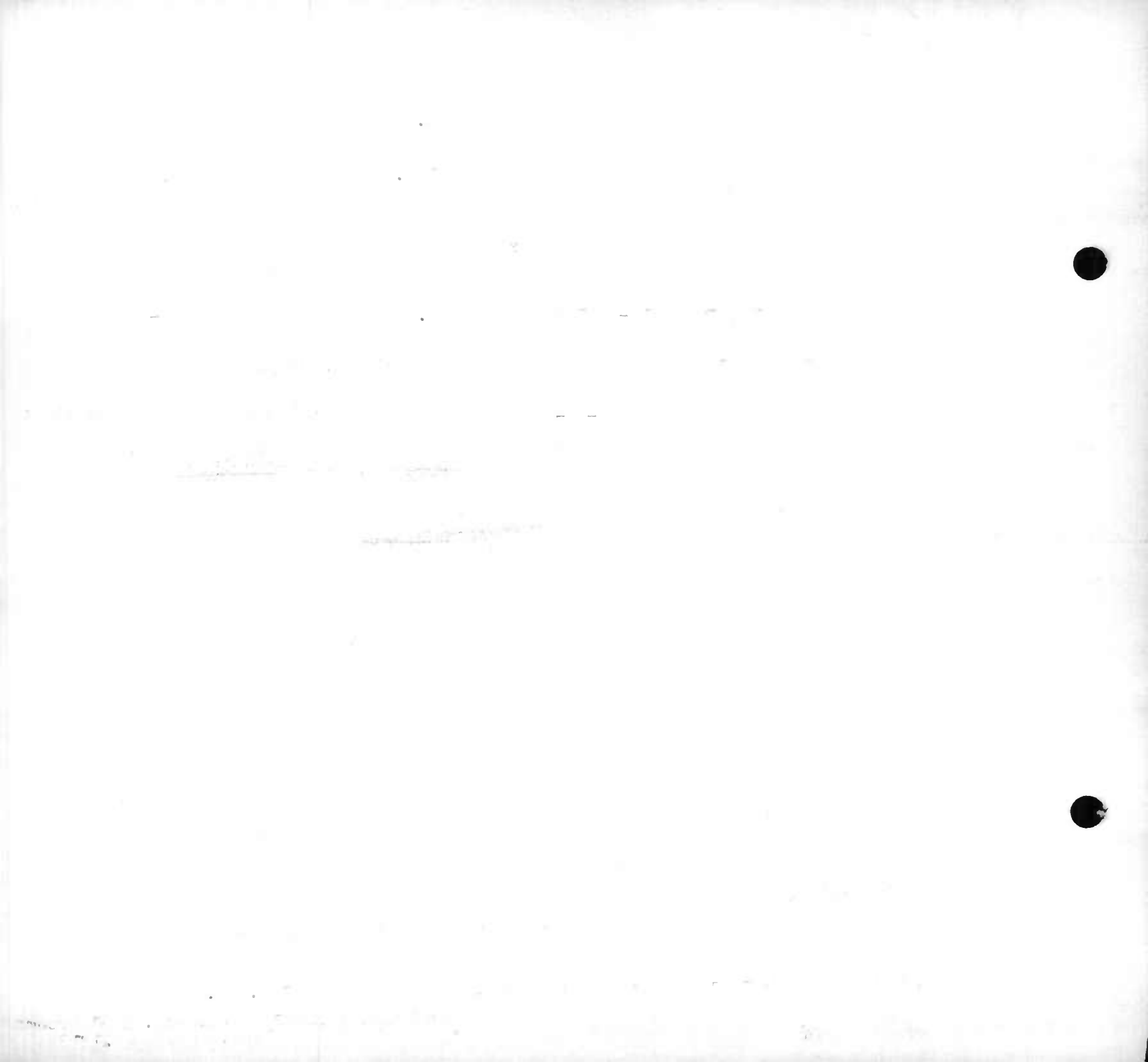




# FUNERAL DIRECTOR: IMPORTANT

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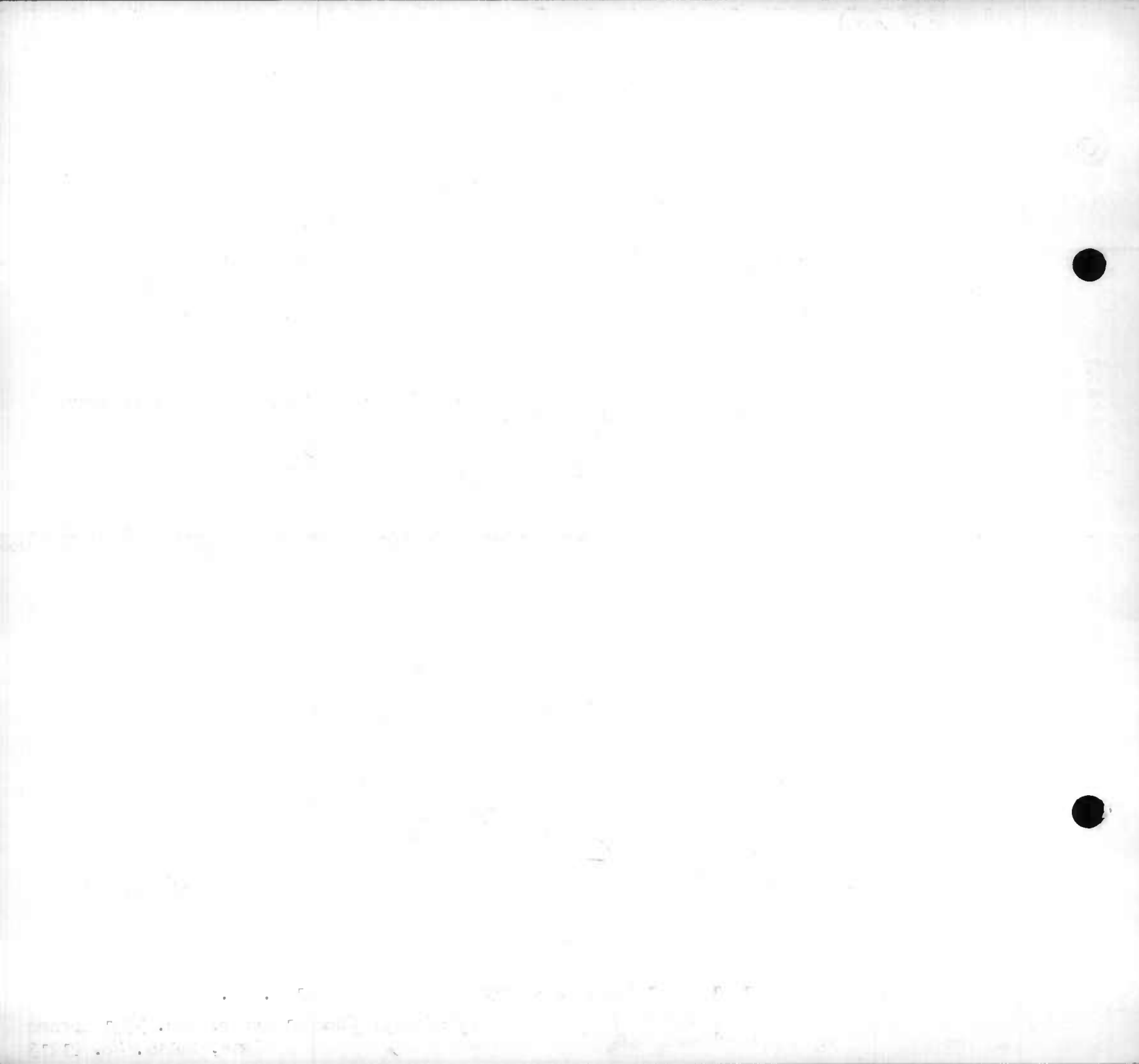
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12127</u>	
K-342 71 12127				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Anthony J Kotalik</u>		2. DATE AND HOUR OF DEATH <u>Dec 28 1971 12:30 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Md. General Hosp</u> <u>48</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2633</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1214 Eutan Pl</u> <u>3583 Shannon Drive</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-99</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>-</u>		13. FATHER'S NAME <u>Vaclav Kotalik</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Handrejch</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-54-6996</u>		17. INFORMANT <u>Mary Conrad (sister)</u> ADDRESS <u>same as above</u>	
18. <u>485X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia bilobate</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Septicemia</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Pulmonary Emboli</u>					
19A. DATE OF OPERATION <u>1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/28/71</u> to <u>12/28/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/28/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Donald H. Hislop</u> DEGREE <u>MD</u>		23B. DATE SIGNED <u>12/28/71</u>		23C. PHYSICIAN'S NAME (Type) <u>DONALD H. HISLOP, MD</u>	
23D. ADDRESS <u>MGH</u>		23E. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/31/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schimmek Funeral Homes, Inc.</u> ADDRESS <u>3331 Brehms Lane, Balto Md 21213</u>			



# FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				REG. NO. 71 12128	
C-200 71 12128		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <b>CHARLES P COOK</b>		2. DATE AND HOUR OF DEATH <b>12/27/71 10:45 PM.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>NORTH CHARLES GENERAL HOSPITAL</b>		A. STATE <b>MARYLAND</b>		B. COUNTY <b>CITY</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>4825 ORVILLE AVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-23-04</b>	9. AGE (In years last birthday) <b>67</b>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EMPLOYEE, B+O RR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
13. FATHER'S NAME <b>UPTON COOK</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET SPIDAL</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>214-09-6587</b>		17. INFORMANT <b>Jennie Cook (wife)</b> ADDRESS <b>same as above</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA, @H lung</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BRONCHOPNEUMONIA with wide spread metastases</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <b>2 NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>YES</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12/12/71</b> to <b>12/27/71</b> and that (I) (we) last saw the deceased alive on <b>12/27/71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edward Sherrer MD</b>		23B. DATE SIGNED <b>28 Dec 71</b>		23C. PHYSICIAN'S NAME (Type) <b>Edward Sherrer MD</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/31/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, MD</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Homes, Inc.</b> ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>	



FUNERAL DIRECTOR: IMPORTANT

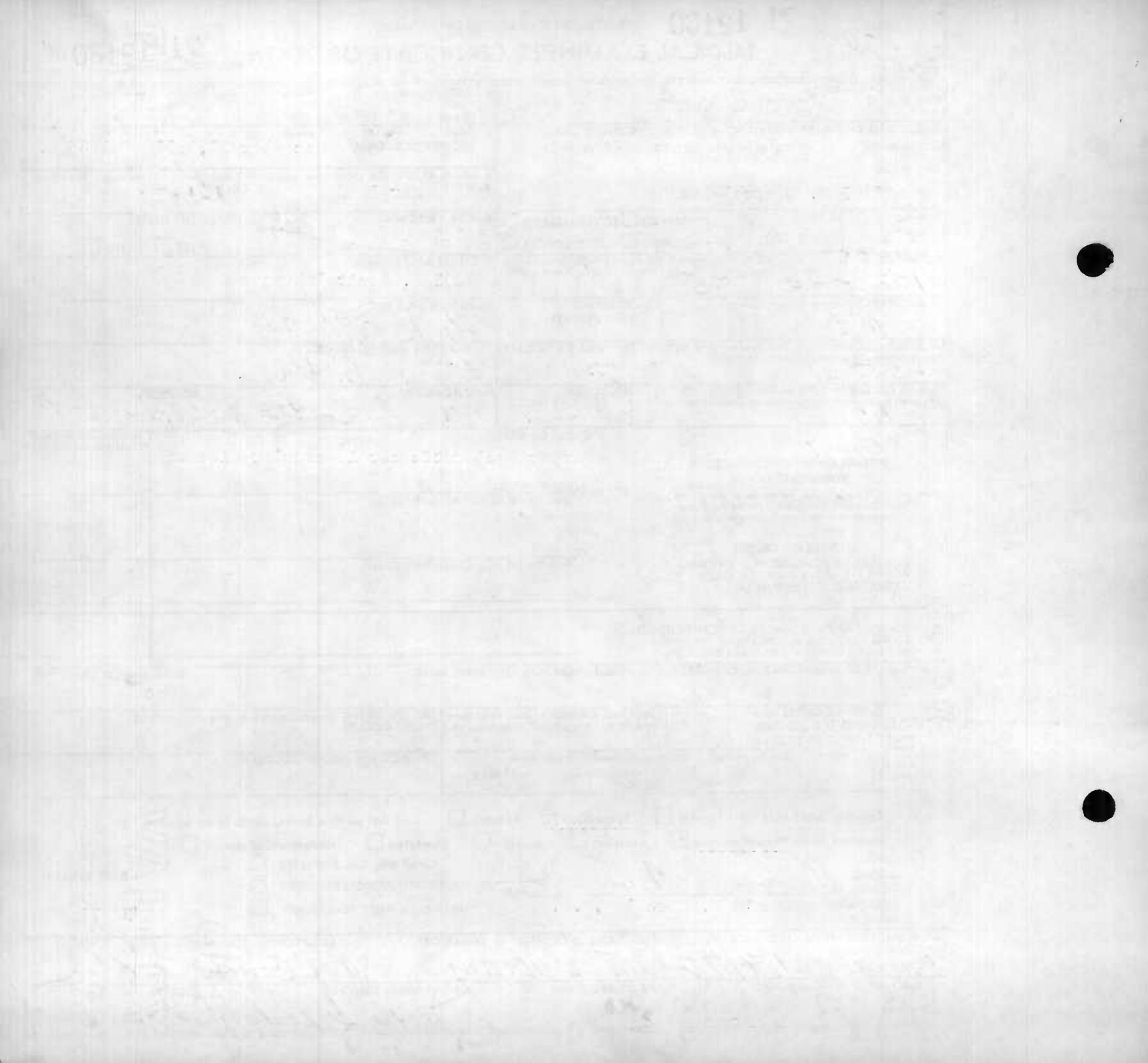
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <b>71 12129</b>	
BIRTH NO. <b>R-400</b>		71 12129		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>William H. Riley</b>			2. DATE AND HOUR OF DEATH <b>12/28/71</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>William H. Riley</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2633</b>		
FULL NAME OF HOSPITAL OR INSTITUTE (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3815 Belair Rd. 2-17-71</b>			C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>M</b>			6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>1/21/89</b>			9. AGE (In years lost birthday) <b>82</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight Conductor</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Penna. R. R.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>"</b>			13. FATHER'S NAME <b>William T. Riley</b>		
14. MOTHER'S MAIDEN NAME <b>Sarah Dailey</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>717-07-8439</b>			17. INFORMANT <b>Anna Riley (wife)</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>0</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <b>Harold H. Burns</b> 23B. DATE SIGNED <b>12-29-71</b> 23C. PHYSICIAN'S NAME (Type) <b>Dr. Harold Burns</b> 23D. ADDRESS <b>8106 Harford Rd.</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b> 24B. DATE <b>12/31/71</b> 24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b> 24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b> 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b> 25B. NAME OF REGISTRAR <b>Viola E. Talley</b> 25C. FUNERAL DIRECTOR <b>Schimunek Funeral Homes, Inc.</b> ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>					

2-17-1972 - Notification from Harold H. Burns, M.D.

8106 Harford Road - Balto., Md. HRS

BALTIMORE CITY HEALTH DEPARTMENT				71 12130			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				71 12130			
BIRTH NO. <u>J-525</u>				REG. NO. <u>71 12130</u>			
1. NAME OF DECEASED (Type or Print) <b>HERBERT JOHNSON</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1403 N. Central Avenue</u>				3. DATE PRONOUNCED DEAD Month Day Year Hour <u>December 31, 1971</u> <u>1:45 A.</u> M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <u>1-28-96</u>				10. AGE (In years last birthday) <u>75</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>Myron Johnson</u>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>	
15. MOTHER'S MAIDEN NAME <u>Laura Anderson</u>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>215-14-7689</u>	
18. INFORMANT <u>Ethel Locke</u>				19. ADDRESS <u>1403 N. Central Ave</u>		20. CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic cardiovascular disease</u>				22. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				24. (B) DUE TO, OR AS A CONSEQUENCE OF:			
25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				26. (C) DUE TO, OR AS A CONSEQUENCE OF:			
27. DATE OF OPERATION				28. CONDITION FOR WHICH OPERATION WAS PERFORMED			
29. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
31. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
33. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				34. HOW DID INJURY OCCUR?			
<p>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE: <u>Ronald N. Kornblum</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>EXAMINER'S NAME (Type) <u>Ronald N. Kornblum, M.D.</u> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12/31/71</u></p> <p>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p>							
35. BURIAL CREMATION, REMOVAL (Specify)				36. DATE			
37. NAME OF CEMETERY or CREMATORY				38. LOCATION (City, town, or county) (State)			
39. DATE REC'D BY HEALTH DEPT.				40. NAME OF REGISTRAR			
41. FUNERAL DIRECTOR				42. ADDRESS			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 12131				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12131	
1. NAME OF DECEASED (Type or Print) LACY BOOTH.				2. DATE AND HOUR OF DEATH 12-30-71 8.00 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission) A. STATE MARYLAND. B. COUNTY BALTIMORE 1202					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE UNION MEMORIAL HOSPITAL 44				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 2423 BARCLAY ST. 21218					
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-30-18	9. AGE (in years last birthday) 53	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONCRETE MAN				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MISSISSIPPI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Robert Booth 2708 Muna St			
18. 571.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pneumonia				CAUSE OF DEATH Hepatic Failure. Portal Cirrhosis - Chronic Alcoholism -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 10-10-19 71 to 12-30-19 71 that (I) (we) last saw the deceased alive on 12-30-19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Anne L. Leddy M.D.				23B. DATE SIGNED 12-30-71		23C. PHYSICIAN'S NAME (Type) DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 11/4/72		24C. NAME of CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) A. Q. County, MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Smith M.D.		25C. FUNERAL DIRECTOR Joseph J. Smith		25D. ADDRESS 1304 N. Central Ave			

What time does the train

Leave at 10:00 AM  
at the depot

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <u>71 12132</u>	
<p><u>W-425</u> <u>71 12132</u></p> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>WILSON, Esther</u></p>		<p>CERTIFICATE OF DEATH</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>33</u> <u>The Johns Hopkins Hospital</u></p>		<p>2. DATE AND HOUR OF DEATH <u>12/29/71</u> <u>5:47 a.m.</u></p> <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1002</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>723 Aisquith Street</u></p>			
<p>5. SEX <u>Female</u> 6. RACE <u>Negro</u></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>9/6/00</u> 9. AGE (In years last birthday) <u>71</u></p> <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses and</u> 10B. KIND OF BUSINESS OR INDUSTRY</p>			
<p>11. BIRTHPLACE (State or foreign country) <u>N.C.</u></p> <p>12. CITIZEN OF WHAT COUNTRY?</p>		<p>13. FATHER'S NAME <u>Josias Haines</u></p> <p>14. MOTHER'S MAIDEN NAME <u>SARAH</u></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p> <p>16. SOCIAL SECURITY NO. <u>217-54-1499</u></p>	
<p>17. INFORMANT <u>Harry Wilson Jr Rte 1 Washington D.C. Biscoe Dring</u></p> <p>18. <u>450X I</u> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE <u>Prob. Acute MI</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u></p> <p>(B) <u>CHF</u> DUE TO, OR AS A CONSEQUENCE OF: <u>years</u></p> <p>(C) <u>prob. Pul. Emboli</u></p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Cellulitis of @ leg</u> <u>4 days</u></p>			
<p>19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</p> <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )</p> <p>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> <p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> 19 <u>76</u> to <u>12/29</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/29</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Daniel L. Roper M.D.</u></p> <p>23C. PHYSICIAN'S NAME (Type) <u>Daniel L. Roper, M.D.</u></p>		<p>23B. DATE SIGNED <u>12/29/71</u></p> <p>23D. ADDRESS <u>Johns Hopkins Hosp</u></p>		<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>12/31/71</u></p> <p>24C. NAME OF CEMETERY OR CREMATORY <u>Int. Catharin Cem.</u> 24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u></p> <p>25B. NAME OF REGISTRAR <u>Blair E. Fisher</u></p>		<p>25C. FUNERAL DIRECTOR <u>Joseph P. Lock</u> ADDRESS <u>1304 N. Central St</u></p>			

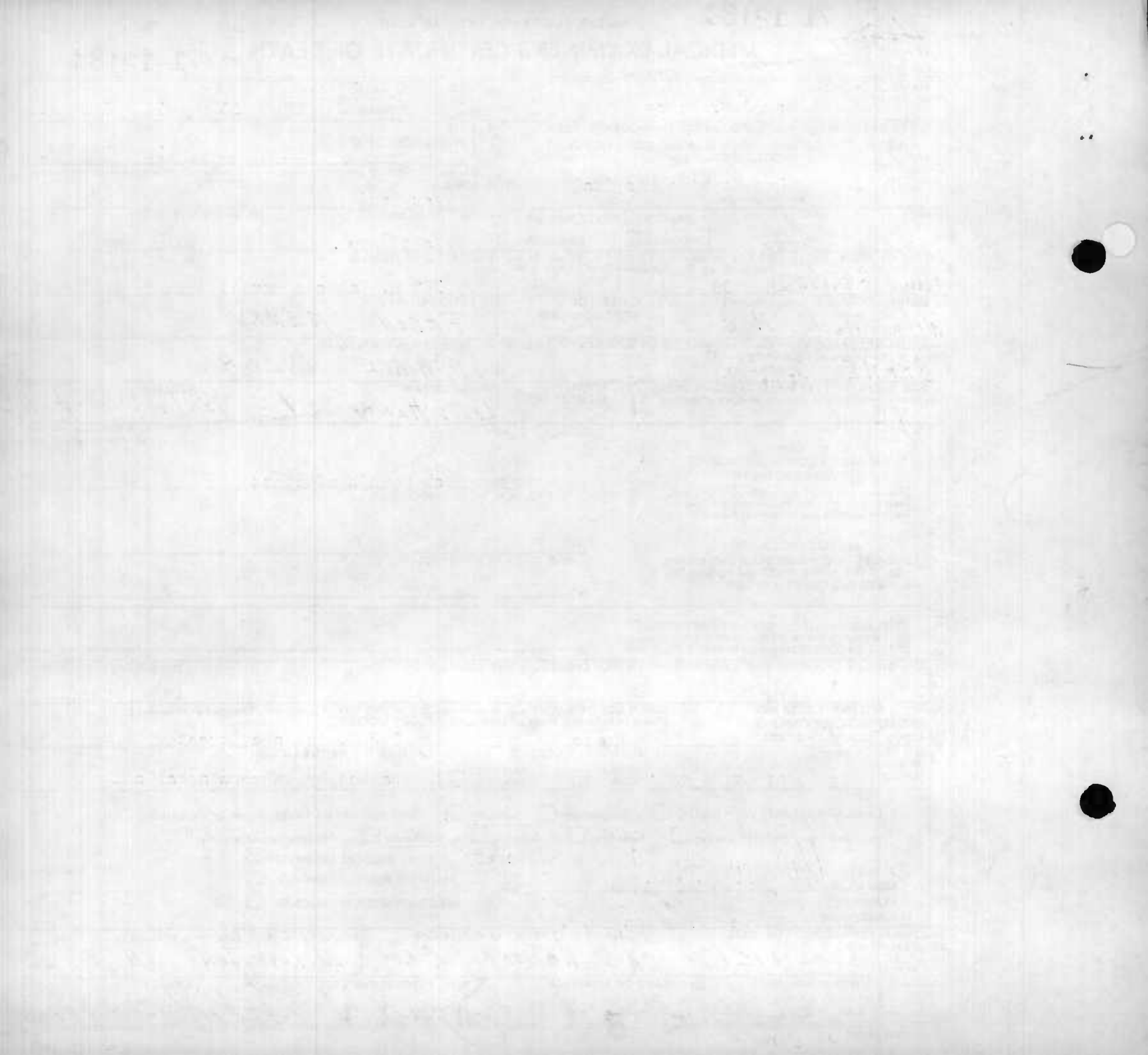


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12133

BIRTH NO.

1. NAME OF DECEASED (Type or Print) David O. Henry		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 31 71 7:50 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 31 71 7:50 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Aug 26, 1932		10. AGE (In years last birthday) 39	
11. BIRTHPLACE (State or foreign country) Wilmington, N.C.		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES		17. SOCIAL SECURITY NO.	
18. INFORMANT LOUIS HENRY		ADDRESS 110 S. TENTH WILMINGTON N.C.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E966X		CAUSE OF DEATH (A) IMMEDIATE CAUSE Stab wounds of chest DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House	
22D. TIME OF INJURY (APPROX.) 12 31 71 6:20 P. M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 302 E. Lanvale Street		22F. HOW DID INJURY OCCUR? Stabbed by unknown assailant	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-1-72	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 1/2/71	
24C. NAME OF CEMETERY or CREMATORY U.S. NATIONAL CEM		24D. LOCATION (City, town, or county) (State) Wilmington N.C.	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Joseph J. Locke		ADDRESS 1304 N. Central	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>S-652</b></span> <span><b>71 12134</b></span> </div>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		<b>REG. NO. 71 12134</b>	
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>Sorenson, Christina C</b>		2. DATE AND HOUR OF DEATH <b>12/27/71 6:05 pm</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>St. Agnes Hospital Emergency Room</b> <b>Wilkens and Caton Ave 21229</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>A.A.</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>11 Wallace Ave 21225</b>			
5. SEX <b>F.</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/9/84</b>	9. AGE (In years last birthday) <b>87</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Charles Wortman</b>		14. MOTHER'S MAIDEN NAME <b>Emma Wiseman</b>	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214 52 7898</b>		17. INFORMANT <b>Ethel Campbell, 109 Hammonds Lane</b> ADDRESS <b>21225</b>	
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Central Vase Accident</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Anticoagulation</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/27</b> 19 <b>71</b> to <b>12/27</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12/27</b> 19 <b>71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Paul R. Ziegler M.D.</b>				23B. DATE SIGNED <b>12/27/71</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/30/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>			
25B. NAME OF REGISTRAR <b>George J. Gonce</b>		25C. FUNERAL DIRECTOR ADDRESS <b>4001 Ritchie Hwy., Baltimore</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

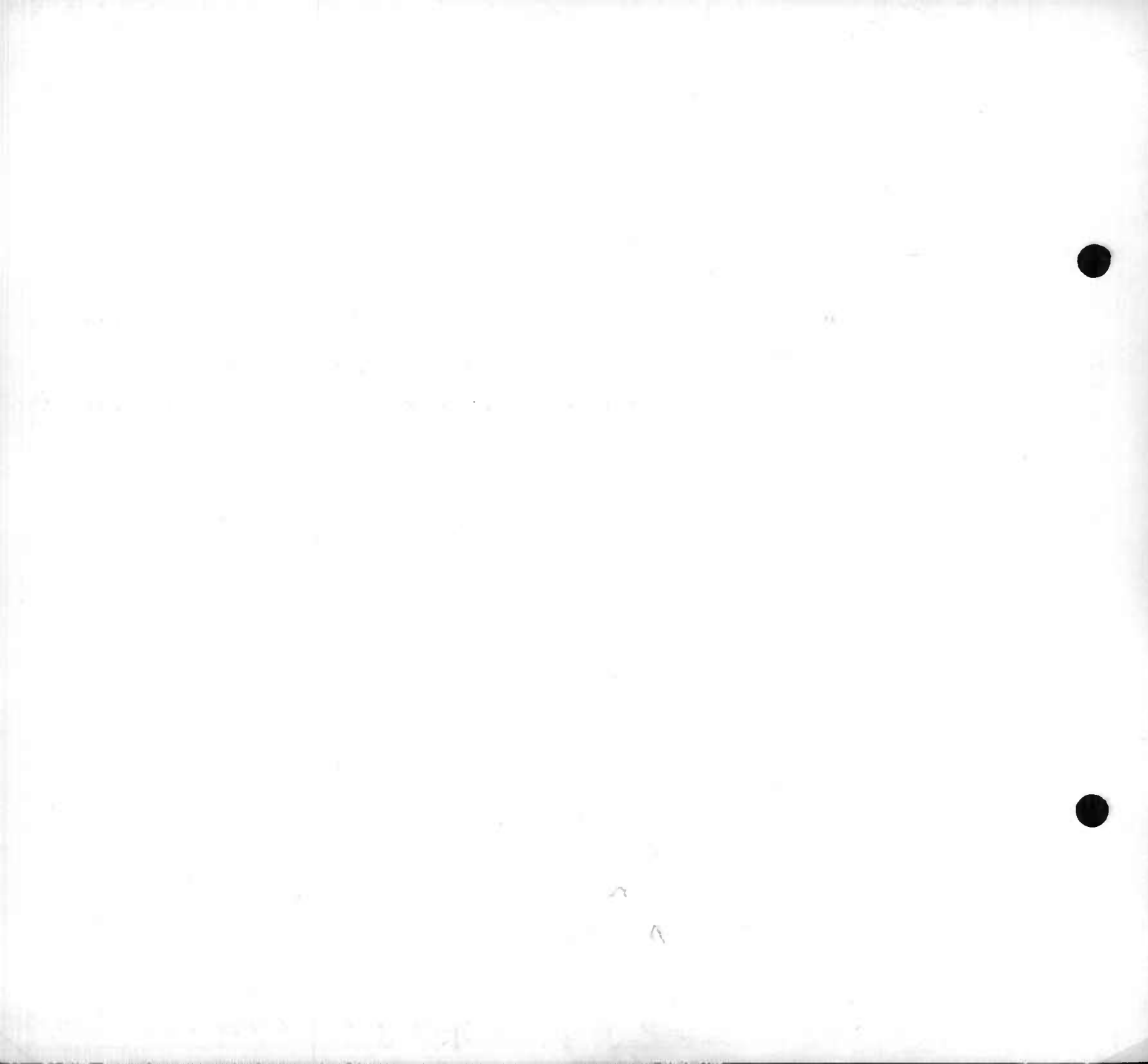
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>	
P-142		71 12135		71 12135	
BIRTH NO. <span style="background-color: black; color: black;">[REDACTED]</span>		1. NAME OF DECEASED (Type or Print) <u>Franklin J. Peoples</u>		2. DATE AND HOUR OF DEATH <u>12/29/71</u> <u>16:30</u> A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1603</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland Hospital</u> <u>38</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>706 N. Gilmore Street</u>					
5. SEX <u>m</u>	6. RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/8/16</u>	9. AGE (in years lost birthday) <u>55</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sparrows Point Plant</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Peoples</u>			
14. MOTHER'S MAIDEN NAME <u>Unk.</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>243-20-8713</u>		17. INFORMANT <u>Mrs. Lucy Peoples 706 N. Gilmore St.</u>			
18. <u>203X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Gram Negative Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Pseudomonas Peritonitis, Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>multiple myeloma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 months.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 15</u> 19 <u>71</u> to <u>Dec 29</u> 19 <u>71</u> that (H) (we) last saw the deceased alive on <u>Dec 29</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard Tomasulo M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/29/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard A. Tomasulo M.D.</u>		23D. ADDRESS <u>Univ. of Md. Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-4-1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jones, Jr.</u>		25C. FUNERAL DIRECTOR <u>Marshall W. Jones, Jr.</u>		25D. ADDRESS <u>735 Harford Avenue</u>	
25E. CITY, TOWN, OR COUNTY <u>Baltimore, Md.</u>		25F. STATE <u>MD.</u>		25G. ZIP CODE <u>21213</u>	



# FUNERAL DIRECTOR: IMPORTANT

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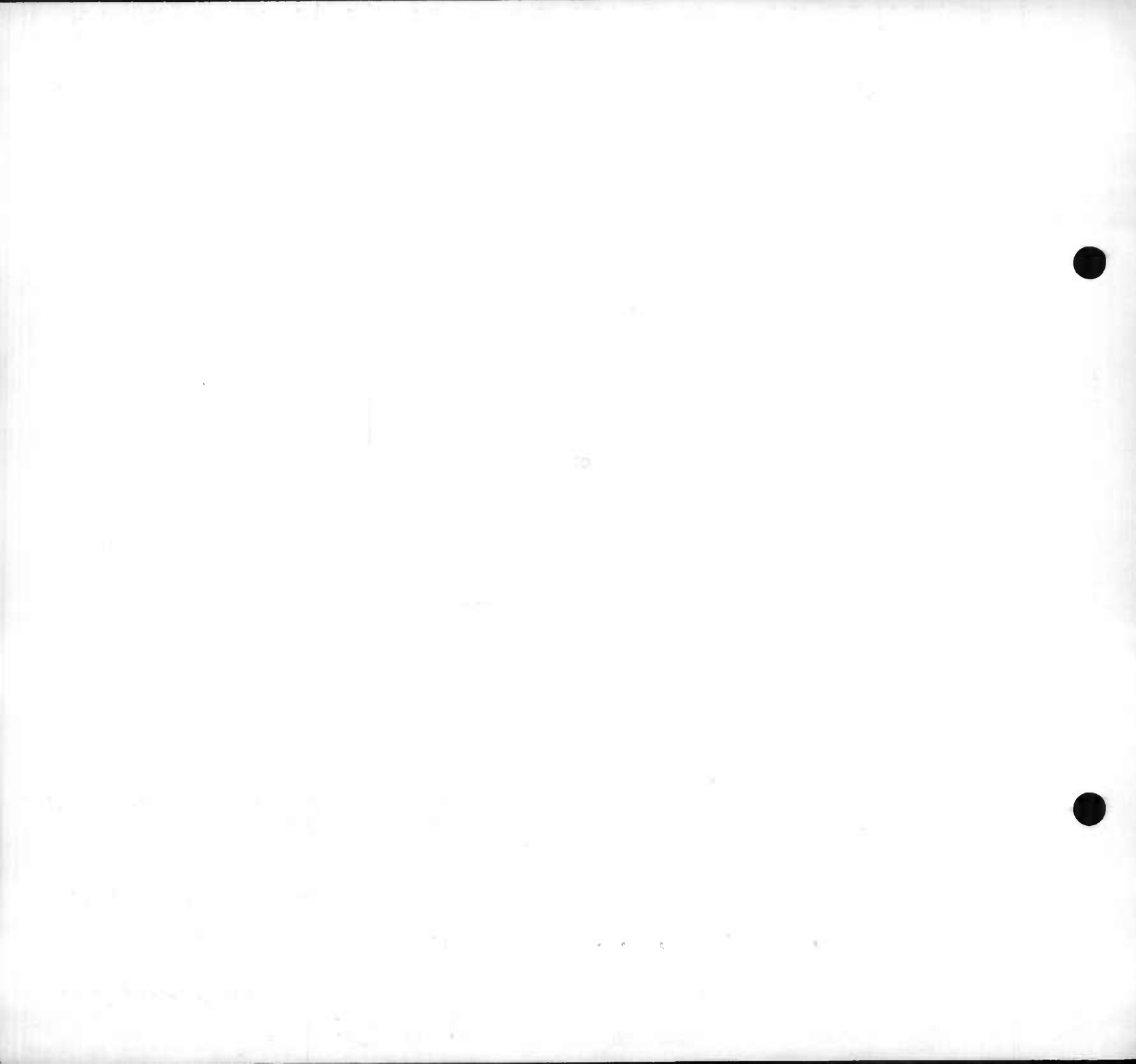
T-000 71 12136		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12136	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Towe, Elizabeth</u>		2. DATE AND HOUR OF DEATH <u>7:50 PM 12/29/71</u> <u>7:50 PM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> & COUNTY <u>1605</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hosp.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2523 Calverton Hgts Av. 21216</u>			
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-6-1893</u>	9. AGE (In years last birthday) <u>78 yr</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Harris</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Marine</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-07-7118B</u>		17. INFORMANT <u>Marcellous Towe</u> ADDRESS <u>2523 Calverton Hgts</u>	
18. <u>174 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Metastasis?</u> (B) <u>Carcinoma Breast</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>-</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12-18-71</u> 19 <u>71</u> to <u>12-29-71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12-29-71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Abdul MAJID MEMON M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-29-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ABDUL MAJID MEMON M.D.</u>		23D. ADDRESS <u>730 Ashbenton St Balto 21216</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1-4-72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Rock Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 8 1972</u>		25B. NAME OF REGISTRAR <u>Charles A. Rice</u>		25C. FUNERAL DIRECTOR ADDRESS <u>661 W. Barre St</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-432 71 12137		BALTIMORE CITY HEALTH DEPARTMENT		71 12137	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Estella Shields</i>			2. DATE AND HOUR OF DEATH <i>Dec 25, 1971 6 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Harbor View Nursing Home</i> <i>1213 Light St</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>City</i> C. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2223 Aisquith St 21218</i>		
5. SEX <i>F</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-11-02</i>	9. AGE (in years last birthday) <i>69</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Horace Wilmer</i>			14. MOTHER'S MAIDEN NAME <i>Martha Foote</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>215-32-2602</i>		
17. INFORMANT <i>Mrs. Myrie Jordan</i>			ADDRESS <i>2529 Harriett Ave</i>		
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular Accident</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Advanced ASCVD with Transient Ischemic Attacks</b> (B) <b>Ischemic Attacks</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>  <b>Years</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>30 March 1971</i> to <i>24 December 1971</i> that (I) <del>last</del> last saw the deceased alive on <i>24 December 1971</i> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <del>not</del> view the body after death.					
23A. SIGNATURE <i>Peter H. Rheinstein, M.D.</i>			23B. DATE SIGNED <i>27 Dec 1971</i>		
23C. PHYSICIAN'S NAME (Type) <i>Peter H. Rheinstein, M.D.</i>			23D. ADDRESS <i>Harbor View Convalescent Center</i>		
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>12-29-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1972</i>		25B. NAME OF REGISTRAR <i>John E. Jones</i>		25C. FUNERAL DIRECTOR <i>P. A. Rose</i>	
				ADDRESS <i>661 Barn St</i>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>71 12138</b>	
<b>W-300 71 12138</b>		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>Mr. Rassie White</b>		2. DATE AND HOUR OF DEATH <b>December 22, 1971 8<sup>25</sup> PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>2543</b>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>2025 W. Fayette St.</b>	
5. SEX <b>Male</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/25/02</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>69</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Walter White</b>		14. MOTHER'S MAIDEN NAME <b>Victoria Harris</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-03-7694</b>	
		17. INFORMANT <b>Robena B. White</b>	
		ADDRESS <b>2514 Huron St.</b>	
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiorespiratory arrest</b>  (B) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>Uremia</b>	
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <b>week</b>  <b>years</b>  <b>days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12, 6, 1971</b> to <b>12-22, 1971</b> and that (I) (we) last saw the deceased alive on <b>12-22-1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>BANDITH</b>		23B. DATE SIGNED <b>12-22-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>BANDITH</b>		23D. ADDRESS <b>Bon Secours Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-28-71</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>661 W. Barre St.</b>	

2514 Huron St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-242 71 12139		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12139	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>NICHOLSON - RUFUS (GIVEN NAME)</b>		2. DATE AND HOUR OF DEATH <b>Dec 22 19 71 12:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1803</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hosp.</b>		E. STREET AND NUMBER <b>1000 Hollins St.</b>			
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-24-04</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Nicholson</b>		14. MOTHER'S MAIDEN NAME <b>Ella Johnson</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mary Reddick 420 E. 28th St.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebrovascular Accident 6 weeks</b> (B) <b>MYOCARDIAL INFARCTION 6 weeks</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Atherosclerosis years</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-16</b> 19 <b>71</b> to <b>12-22</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12-22</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edmund P. Garvey MD</b>		23B. DATE SIGNED <b>12-22-71</b>		23C. PHYSICIAN'S NAME (Type) <b>GARVEY MD</b>	
23D. ADDRESS <b>3001 S. HANCOCK ST Baltimore 21230</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-28-71</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>661 W. Barre St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

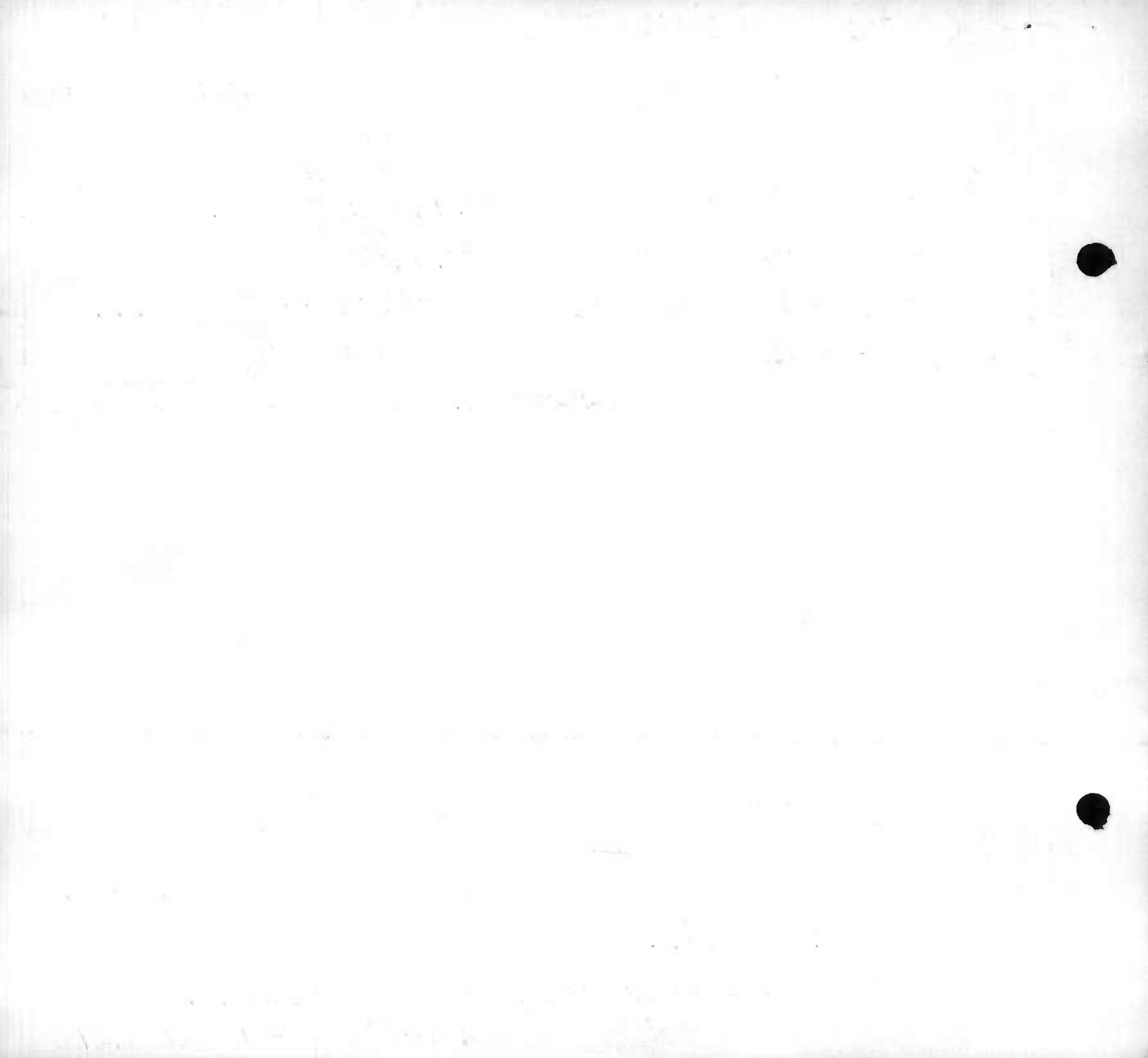
Baltimore City Health Department				REG. NO. 71 12140	
S-610 71 12140		BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARJORIE ANNE SCHARF		2. DATE AND HOUR OF DEATH 12/28/71 3:00 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD. CECIL	
		C. CITY OR TOWN RISING SUN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 22 Reynolds Ave.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/03/21	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEHOLD MAINTENANCE		10B. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CARL PULLER			
14. MOTHER'S MAIDEN NAME ANNE LOWERS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service 170			
16. SOCIAL SECURITY NO.		17. INFORMANT MICHAEL P. THUMME DOLPHIN, PA			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Carcinoma lung metastatic to chest wall, mediastinum		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mos	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 24 1971 to 12/28 1971 that (I) (we) last saw the deceased alive on 12/28 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Noble Hansen				23B. DATE SIGNED 12/28/71	
23C. PHYSICIAN'S NAME (Type) NOBLE M. HANSEN				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-31-71		24C. NAME OF CEMETERY OR CREMATORY BROOKVIEW	
24D. LOCATION RISING SUN, MD.		25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972			
25B. NAME OF REGISTRAR Robert E. Hansen		25C. FUNERAL DIRECTOR ROBERT E. HANSEN			
25D. ADDRESS 100		25E. FUNERAL HOME RISING SUN			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-360		71 12141		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12141	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Lila Gaither				December 26, 1971 11:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Gould Convalescent Home				Maryland BALTO 5300			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore 021220		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				Rt. 15, Box 315 Chester Rd.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	10. Under 1 Yr. Months Days	
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 18, 1906		65		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Tavern Owner		Self Employed		Washington D.C.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
- Franklin				Sadie Jennings			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		220-14-3743		Mr. Stanley Gaither- 3900 Southern Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 12/24/19 71 to 12/26/19 71 that (I) (we) last saw the deceased alive on 12/24/19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Albert B. Bradley				12/28/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Albert B. Bradley, M.D.				4900 Belair Road 21206			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-29-71		Oruid Ridge Cemetery		Pikesville, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 3 1972		Robert E. Gaither, M.D.		John C. Miller Inc-4115 Belair Rd.-21206			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12142</b>	
<b>L-520</b> <b>71 12142</b>		<b>CERTIFICATE OF DEATH</b>			
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print)		<b>2. DATE AND HOUR OF DEATH</b> Dec. 28, 1971		10 p. M.	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CERTIFICATE AMENDED</b> <b>40 St. Agnes Hospital 1-28-72</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Md. <b>2748</b>			
<b>5. SEX</b> female		<b>6. RACE</b> white		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Saleslady		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> Sears Roebuck		<b>8. DATE OF BIRTH</b> 2/18/92	
<b>13. FATHER'S NAME</b> John Andrews		<b>14. MOTHER'S MAIDEN NAME</b> Ellen Moran		<b>9. AGE</b> (In years last birthday) 79	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) 218-26-4434		<b>16. SOCIAL SECURITY NO.</b> 218-26-4434		<b>17. INFORMANT</b> Catherine Foss, Dght., above	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <b>RUPTURE ANEURYSM, AORTA</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROSIS.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 1/2 HRS.</b> <b>10 YRS.?</b>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> 0		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> 12/28/71 <b>to</b> 12/28/71 <b>and that (I) (we) lost saw the deceased alive on</b> 12/28/71 <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> Paul R. Ziegler M.D.		<b>23B. DATE SIGNED</b> 12/30/71		<b>23C. PHYSICIAN'S NAME</b> (Type) PAUL R. ZIEGLER M.D.	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) Burial		<b>24B. DATE</b> 12/31/71		<b>24C. NAME OF CEMETERY or CREMATORY</b> Moreland Mem. Park	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> JAN 3 1972		<b>25B. NAME OF REGISTRAR</b> Schimunek, Funeral Home, Inc.		<b>25C. FUNERAL DIRECTOR</b> 13331 Brehms Lane	
<b>24D. LOCATION</b> (City, town, or county) (State) Baltimore, Md.		<b>24E. ADDRESS</b> 13331 Brehms Lane			

1-28-1972 - Correction Form from Funeral Director - Schimunek Funeral Home, Inc.  
and notification signed by Paul R. Ziegler, M.D.  
200 Chestnut Hill Dr.  
Ellicott City, Maryland

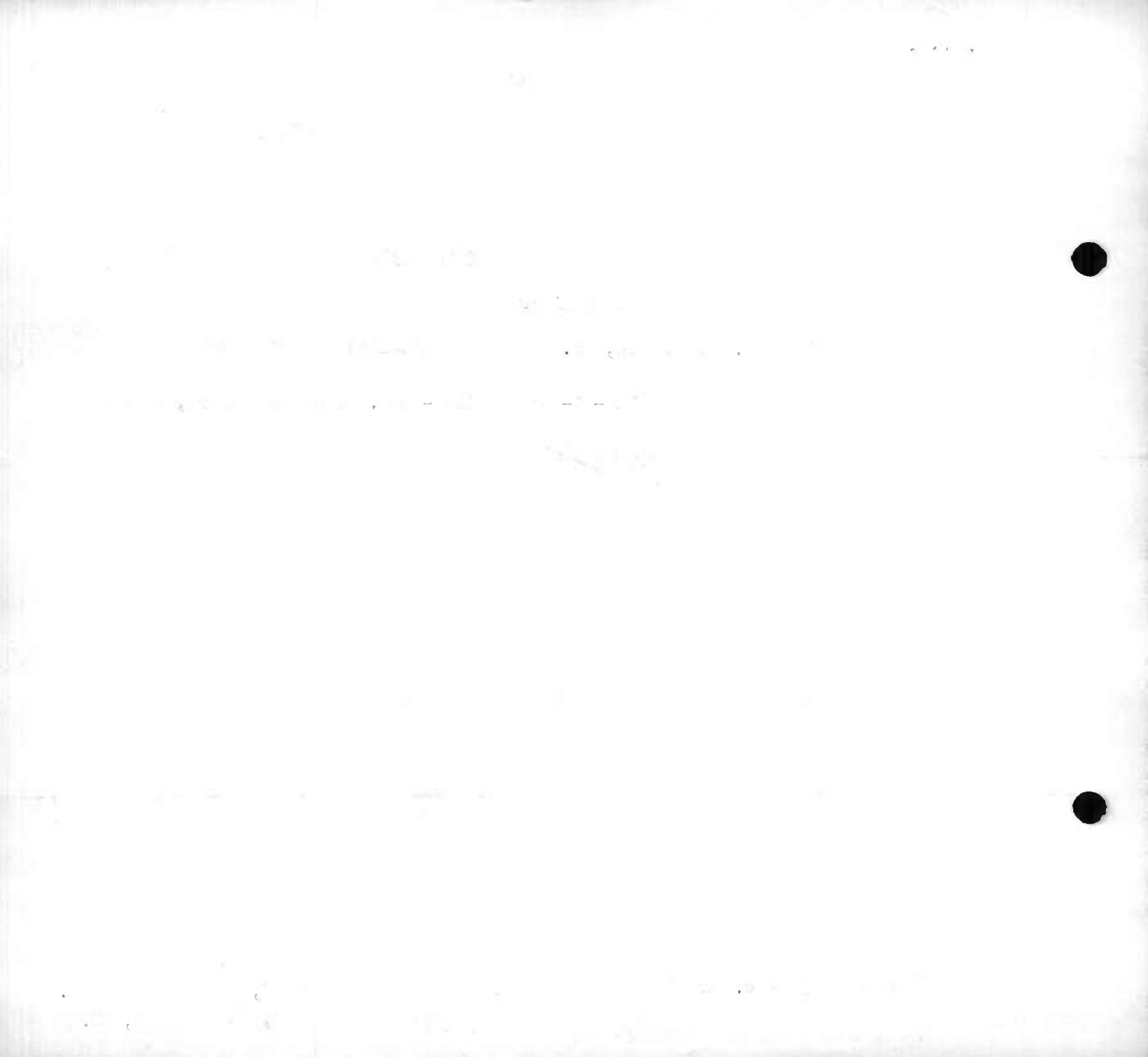
HRS



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>71 12143</b>	
BIRTH NO. <b>S-362 71 12143</b>		DATE AND HOUR OF DEATH <b>12-28-71 13<sup>00</sup> P.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>JAMES F. STRAUSBURG, JR.</b>		2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>ANNE ARUNDEL</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MD - GEN Hosp</b>		C. CITY OR TOWN <b>Gambrells</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 May 1944</b> 9. AGE (in years last birthday) <b>27</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Eastern Airlines</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James F. Strausburg, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Kathleen Effland</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-42-6684</b>	
17. INFORMANT <b>Wife - Mrs. Joyce Strausburg, same as 4.</b>		ADDRESS	
18. <b>172.9 I</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Autopsy</b> IMMEDIATE CAUSE <b>METASTATIC MALIGNANT</b> DUE TO, OR AS A CONSEQUENCE OF: <b>MELOMOMA</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-24</b> 19 <b>71</b> to <b>12-28</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12-28</b> 19 <b>71</b> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Maryanne</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>MARYANN</b>		23D. ADDRESS <b>MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>31 Dec. 71</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>SUNSET MEMORIAL PARK</b>		24D. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>MARK</b>		25D. ADDRESS <b>FUNERAL HOME, GLEN BURNIE, MD.</b>	



Released by Special Agent Medical Examiner  
FURNAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**BALTIMORE CITY HEALTH DEPARTMENT**  
**CERTIFICATE OF DEATH**

REG. NO. **71 12144**

**T-612 71 12144**

**BIRTH NO.**

**1. NAME OF DECEASED**  
(Type or Print) **Mrs. Nelle Travis**

**2. DATE AND HOUR OF DEATH**  
**12-29-71 8.15 P.M.**

**3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD**

**4. USUAL RESIDENCE** (Where deceased lived. If institutions residence before admission)  
**A. STATE** **Maryland**  
**B. COUNTY** **1307**

**5. FULL NAME OF HOSPITAL OR INSTITUTION** (If not in hospital or institution, give street address or location)  
**Keswick Home for Incurables of Baltimore City**

**6. CITY OR TOWN** **Baltimore**

**7. INSIDE CITY LIMITS?** YES ☒ NO ☐

**8. STREET AND NUMBER**  
**Keswick - 700 W. 40th. St.**

**9. SEX** **Female**

**10. RACE** **White**

**11. MARRIED** ☐ **NEVER MARRIED** ☐  
**WIDOWED** ☒ **DIVORCED** ☐

**12. DATE OF BIRTH** **12-19-86**

**13. AGE** (in years last birthday) **85 yrs.**

**14. Under 1 Yr. Months Days** **Under 24 Hrs. Min.**

**15. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)  
**Saleslady - Hutzler's Dept. Store**

**16. BIRTHPLACE** (State or foreign country)  
**Dulan, Florida**

**17. CITIZEN OF WHAT COUNTRY?** **USA**

**18. FATHER'S NAME** **George Boston**

**19. MOTHER'S MAIDEN NAME** **Henrietta Moore**

**20. Was Deceased Ever in U. S. Armed Forces?** (Yes, no or unknown) (If yes, give war or dates of service)  
**---**

**21. SOCIAL SECURITY NO.** **212-05-9260**

**22. INFORMANT** **Keswick Home 700 W. 40th. St.**

**23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**  
(This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
**Ural Respiratory Infection**

**24. ANTECEDENT CAUSES**  
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  
**ASCVD with Parkinsonism**

**25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).**  
**Fracture of the right hip**

**26. DATE OF OPERATION** **12-13-71**

**27. CONDITION FOR WHICH OPERATION WAS PERFORMED**

**28. AUTOPSY?** (Yes or No) **No**

**29. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?**

**30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH** (notify medical examiner) ☐

**31. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **Nursing Home**

**32. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)  
**700 W. 40th St.**

**33. TIME OF INJURY** (Month) (Day) (Year) (Hour) (Approx.) **12-13-71**

**34. INJURY OCCURRED**  
**While At Work** ☐ **Not While At Work** ☒

**35. HOW DID INJURY OCCUR?** **FELL TO FLOOR**

**36. I certify that (I) (this hospital) attended the deceased from 4 Nov 1971 to 29 Dec 1971**  
that (I) (we) lost saw the deceased alive on **29 Dec 1971** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

**37. SIGNATURE** **Aubrey D. Richardson M.D.**

**38. DATE SIGNED** **29 Dec 1971**

**39. PHYSICIAN'S NAME** (Type)  
**Aubrey D. Richardson M.D.**

**40. ADDRESS**  
**700 W. 40th St. Baltimore Md 21211**

**41. BURIAL CREMATION, REMOVAL (Specify)** **12/30/71**

**42. DATE** **12/30/71**

**43. NAME OF CEMETERY OR CREMATORY** **H. Lincoln Green**

**44. LOCATION** (City, town, or county) (State)  
**Washington D.C.**

**45. DATE REC'D BY HEALTH DEPT.** **JAN 3 1972**

**46. NAME OF REGISTRAR** **John E. Taylor, M.D.**

**47. FUNERAL DIRECTOR** **Robert A. Baranov, Severna Park, Md.**

**48. ADDRESS**

unclassified

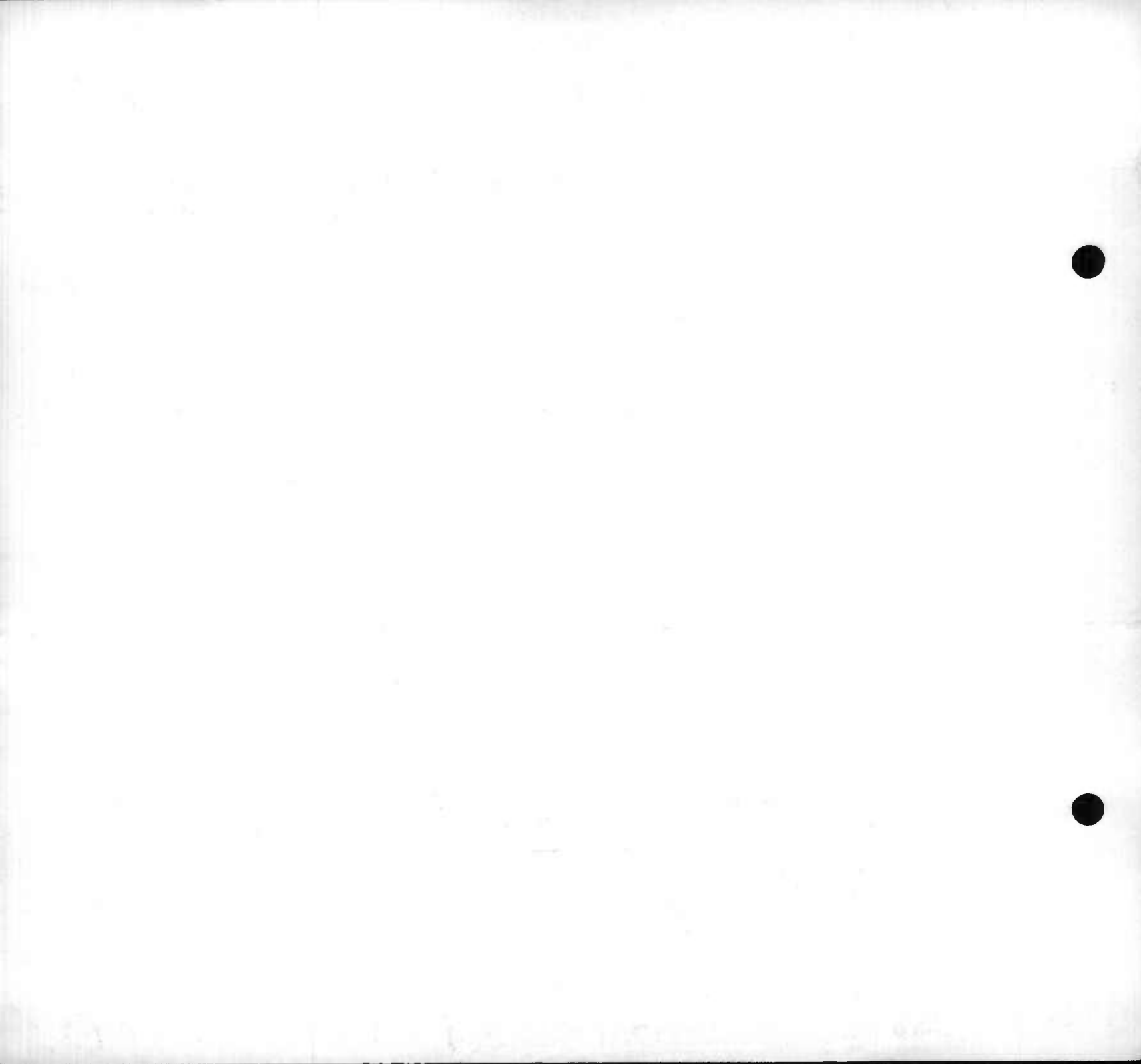
unclassified of unclassified unclassified

Cremation 12/24/11 At Forest Green Washington D.C.  
Lester D. H. Jr.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

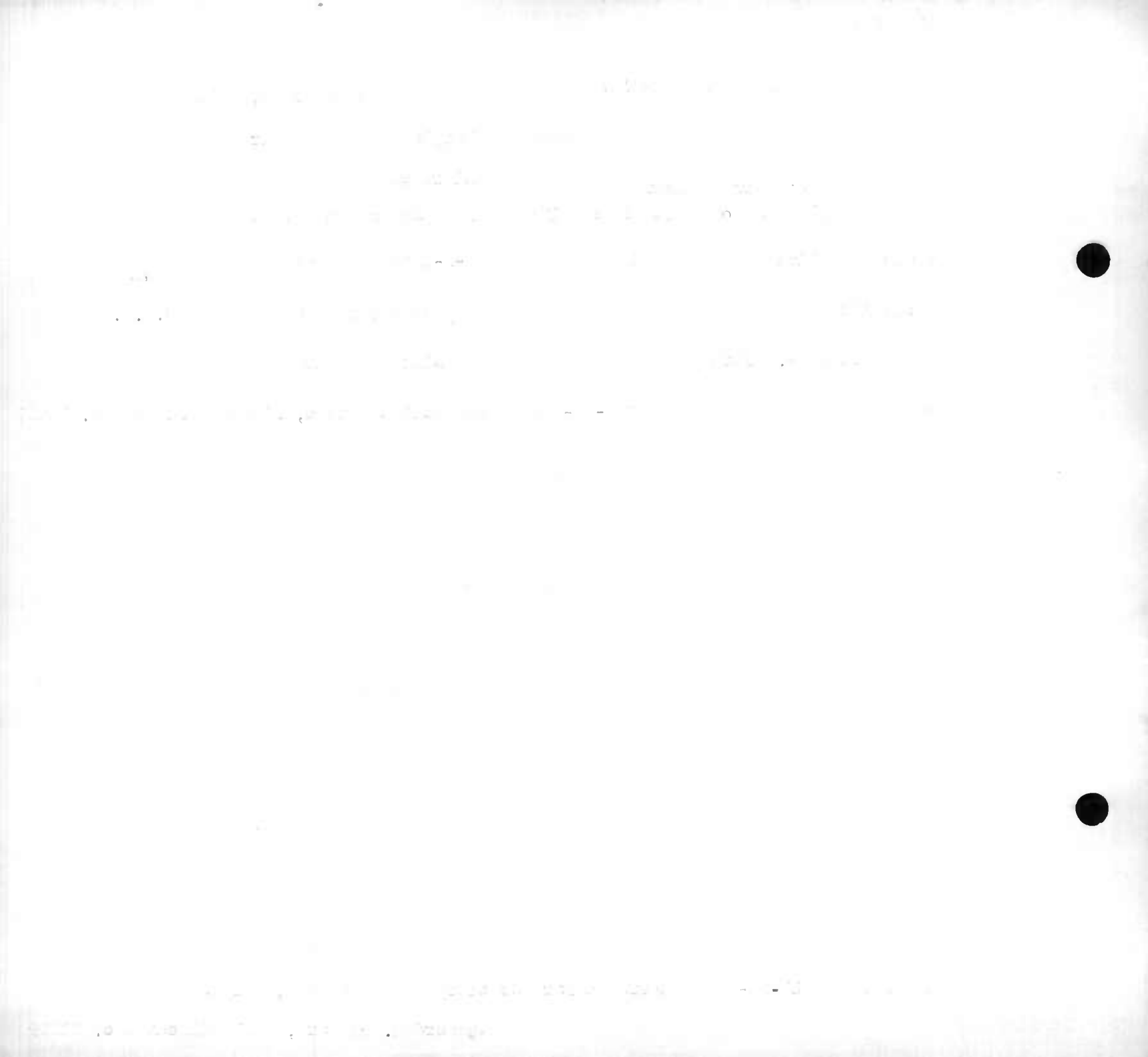
C-400 71 12145		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12145	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>THOMAS CULLY</b>		2. DATE AND HOUR OF DEATH <b>12/29/71</b> <b>1:30 P.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2734</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Gould Convalescent Home</b>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>6200 Everall Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1889</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	
13. FATHER'S NAME <b>Robert Cully</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Armstrong</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-9033</b>		17. INFORMANT <b>George Cully - 6200 Everall Ave</b>	
18. <b>412.3 I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pericardial Vascular Drugging</b>		<b>2 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <b>Coronary Arteriosclerosis</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Chronic Brain Anemia; Dehydration; Conduction Problems</b>					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/30/71</b> to <b>12/29/71</b> that (I) (we) last saw the deceased alive on <b>12/28/71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Albert B. Bradley</b>		23B. DATE SIGNED <b>12/29/71</b>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>12/30/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>John C. Miller</b>		25C. FUNERAL DIRECTOR <b>John C. Miller Inc. - 6415 Belkin Rd.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 12146</b>	
BIRTH NO. <b>4-632 71 12146</b>		1. NAME OF DECEASED (Type or Print) <b>IDA MAY HARTKE</b>		2. DATE AND HOUR OF DEATH <b>December 28, 1971</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>90 Hood Nursing Home 5213 Edmondson Avenue 21229</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Howard</b> C. CITY OR TOWN <b>Elkridge</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>5900 Augustine Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-1880</b>	9. AGE (In years last birthday) <b>91</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>Charles W. Furley</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-48-9738</b>		
17. INFORMANT <b>Miss Nellie Hartke, 5900 Augustine Ave. 21227</b>			ADDRESS		
18. CAUSE OF DEATH <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>(A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) H.C.V.D. - MYOCARDIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C) GENERALIZED AORTOSCLEROSIS</b>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <b>12/27</b> 19 <b>71</b> to <b>12/28</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12/27</b> 19 <b>71</b> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John H. Shuman MD</b>				23B. DATE SIGNED <b>12/28/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>John H. Shuman MD</b>				23D. ADDRESS <b>5213 Edmondson Ave. Apt. 28, MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-31-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Woodlawn, Maryland</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 3 1972</b>			
25B. NAME OF REGISTRAR <b>John H. Shuman MD</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			

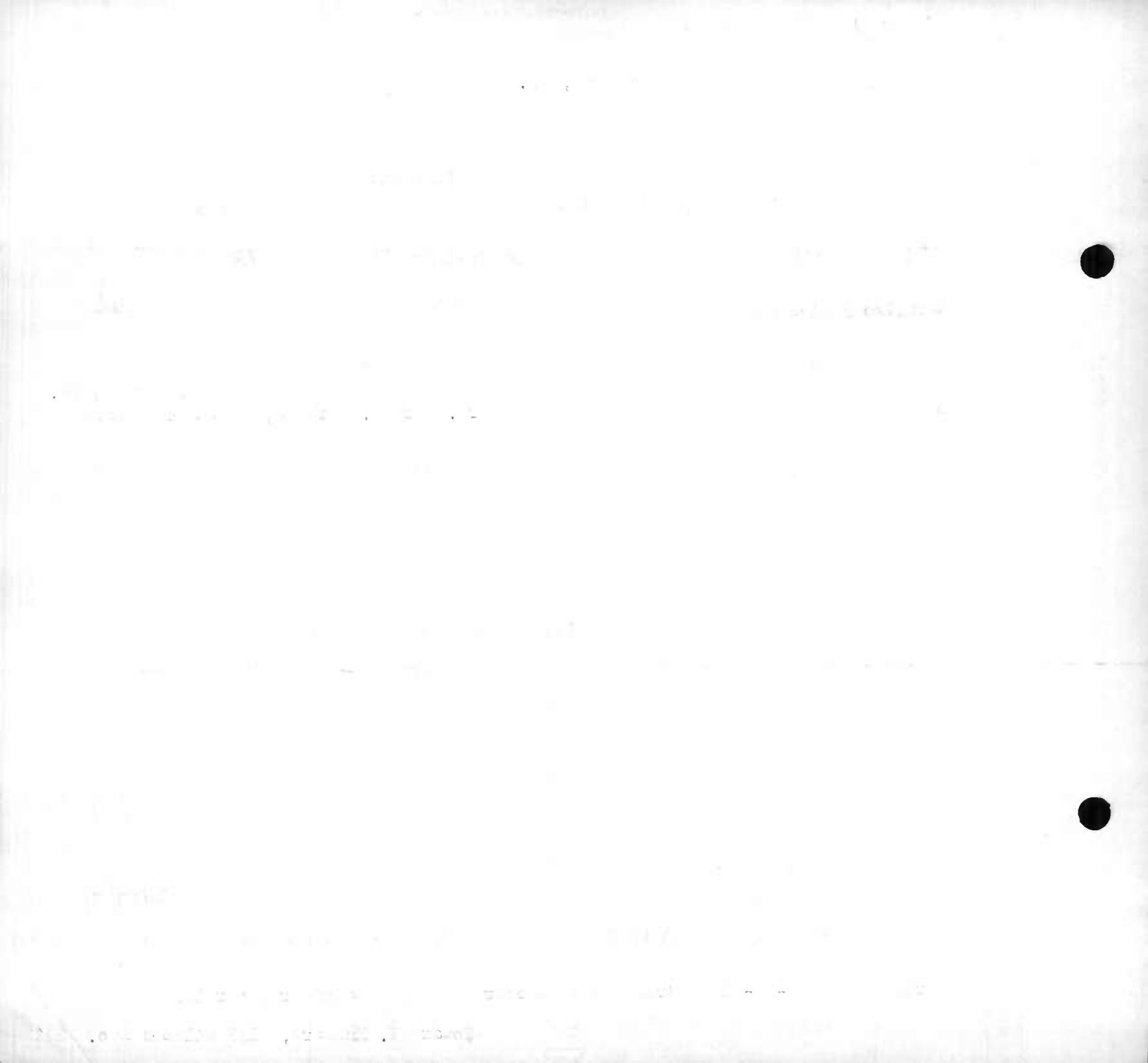




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>71 12147</b></p>	
<p><b>BIRTH NO.</b> <b>G-400 71 12147</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>Dec 27, 1971 5:30 A.M.</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>MAJOR D. GAYLE, SR.</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <b>A. STATE</b> <b>MD</b> <b>B. COUNTY</b> <b>903</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>LUTHERAN HOSPITAL, 730 ASHBURTON ST, BALTIMORE, MD 21216.</b></p>		<p><b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p><b>5. SEX</b> <b>M</b> <b>6. RACE</b> <b>W</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b> <b>11-26-93</b> <b>9. AGE (in years last birthday)</b> <b>78</b> <b>If Under 1 Yr. Months: Days: Hours: Min.</b></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Maritime Policeman</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>VA</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b></p>	
<p><b>13. FATHER'S NAME</b> <b>Unknown</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>ADDRESS</b> <b>Mrs. Mary F. Scruggs, 3847 Autumn Lane Richmond, Va.</b></p>	
<p><b>18. CAUSE OF DEATH</b> <b>I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>1</b> This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. <b>ANTECEDENT CAUSES</b> <b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b></p>		<p><b>(A) IMMEDIATE CAUSE</b> <b>CARCINOMA OF THE PROSTATE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b></p>	
<p><b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <b>PULMONARY EMPHYSEMA.</b></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>PROBABLY A FEW MONTHS.</b></p>	
<p><b>19A. DATE OF OPERATION</b> <b>0</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY (Yes or No)</b> <b>NO</b> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>12/22/1971</b> <b>to</b> <b>12/27/1971</b> <b>that (I) (we) last saw the deceased alive on</b> <b>12/27/1971</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <b>DEGREE</b> <b>23B. DATE SIGNED</b> <b>Azad Cader</b> <b>12/27/71</b></p>		<p><b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input type="checkbox"/></p>	
<p><b>23C. PHYSICIAN'S NAME (Type)</b> <b>23D. ADDRESS</b> <b>AZAD CADER</b> <b>LUTHERAN HOSPITAL, BALTO, MD 21216</b></p>		<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>24B. DATE</b> <b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>24D. LOCATION</b> (City, town, or county) (State) <b>Burial</b> <b>12-30-71</b> <b>Greenmount Cemetery</b> <b>Baltimore, Maryland</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>25B. NAME OF REGISTRAR</b> <b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <b>JAN 3 1972</b> <b>Robert J. ...</b> <b>Howard H. Hubbard</b> <b>4107 Wilkens Ave. 21229</b></p>		<p><b>VS 150-REV. 1/1/68</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12148</u>	
<div style="display: flex; justify-content: space-between;"> <span>G-600 71 12148</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ALOIS GEIER		December 28, 1971		4:55 a. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
00 625 Brisbane Road Baltimore, Maryland 21229		Maryland			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		625 Brisbane Road			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-10-1889	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Baker				Germany	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Heinrich Geier		Unknown		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216-28-2732		21061	
		Mr. Carl H. Geier, 278 Cross Creek Drive			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <i>Massive Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Arteriosclerosis - A.S. heart disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Senile</i>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>Dec. 28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Dec. 28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Stanley Ankudas</i>				<u>12.28.71</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Stanley Ankudas				1101 Maiden Choice Lane, Baltimore, Md. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12-31-71		Loudon Park Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 3 1972		<i>Robert E. Taylor, M.D.</i>		Howard H. Hubbard, 4107 Wilkens Ave. 21229	

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71 12149

BALTIMORE CITY HEALTH DEPARTMENT

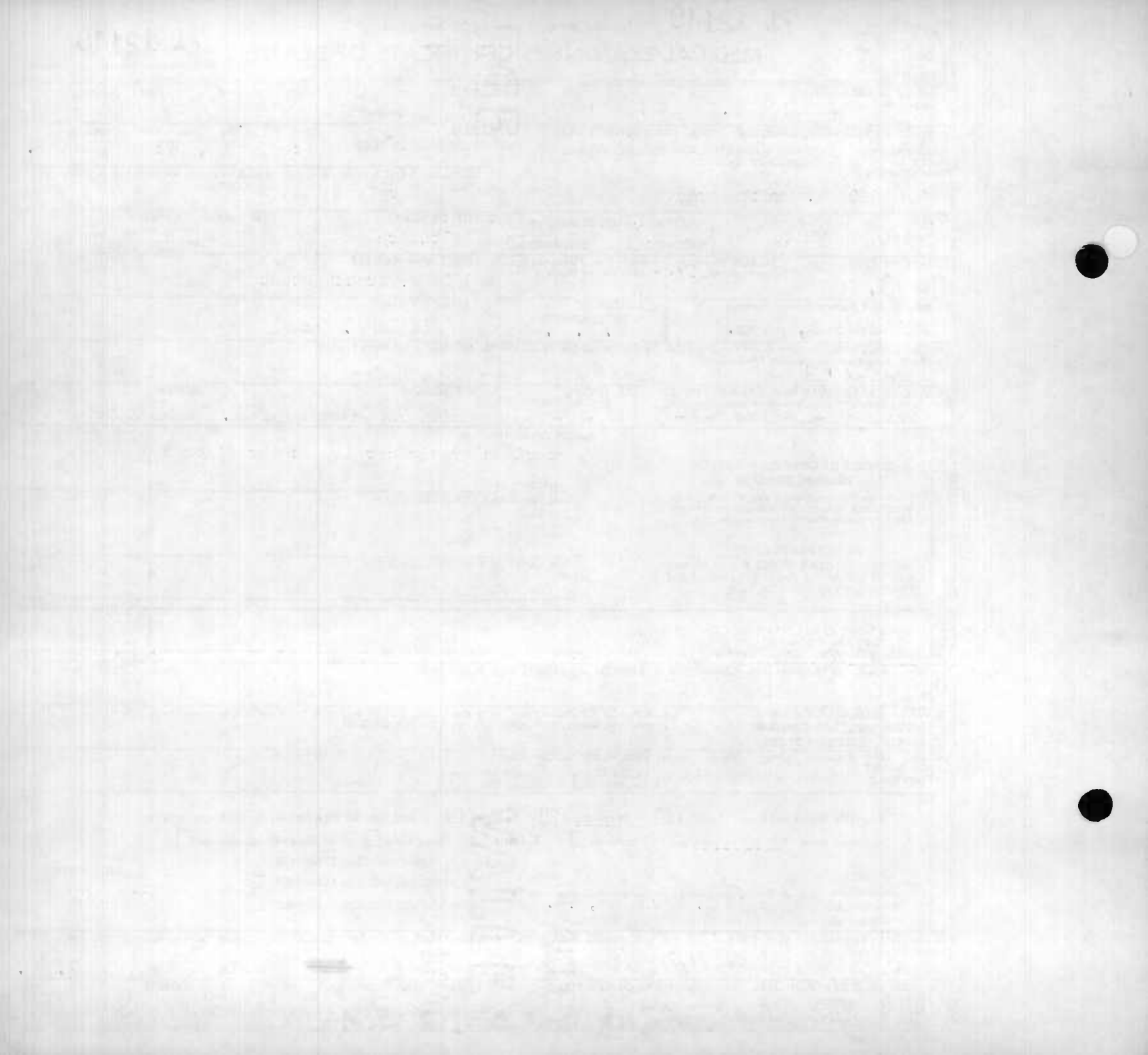
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12149

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM F. GROOME</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>001524 W. Pratt Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 28, 1971</b> 11:00 P. M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>July 5, 1901</b>		10. AGE (In years, last birthday) <b>71</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William F. Groome</b>		14. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1902</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grave Yard Worker</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Grave Yard</b>	
15. MOTHER'S MAIDEN NAME <b>Catherine</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes 2-21-20 to 4-30-23</b>	
17. SOCIAL SECURITY NO. <b>217-07-6853</b>		18. INFORMANT <b>Catherine Groome</b> ADDRESS <b>1524 W. Pratt Street</b>	
19. <b>412, 41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>	
20. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>12/29/71</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec 31/71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Green Haven Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Ritchie Highway, Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>	
25C. FUNERAL DIRECTOR <b>Thomas J. Kennedy Jr.</b>		ADDRESS <b>Holmes &amp; G. [Signature]</b>	



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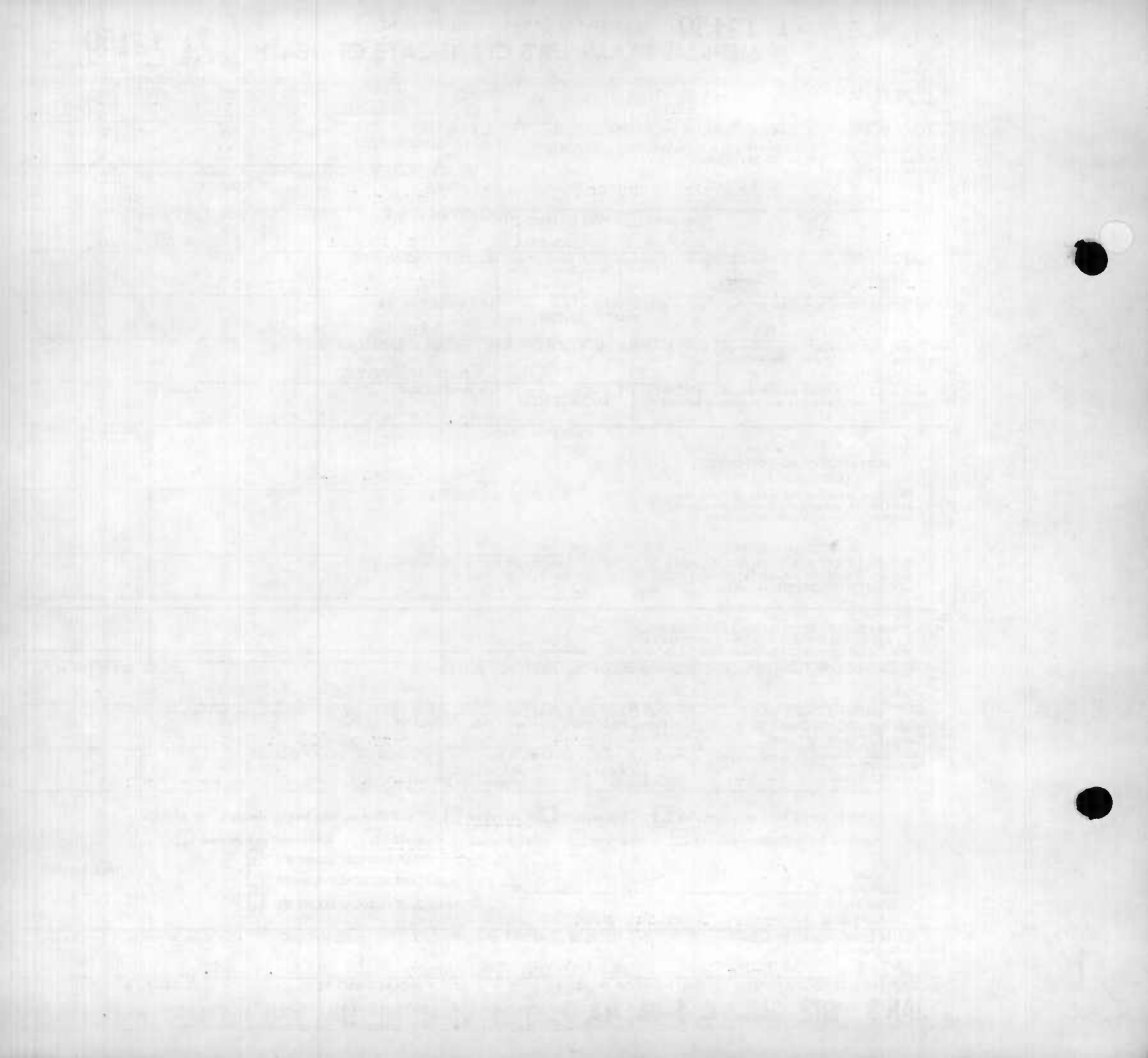
0-361 71 12150 BALTIMORE CITY HEALTH DEPARTMENT 71 12150

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Outterbridge Leroy (Outterbridge)</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>12</b> Day <b>31</b> Year <b>71</b> Hour <b>8:05 P.M.</b> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>12</b> Day <b>31</b> Year <b>71</b> Hour <b>8:05 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>9-23-36</b>		10. AGE (In years last birthday) <b>35</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Willie Outterbridge</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1204</b>	
15. MOTHER'S MAIDEN NAME <b>Sarah Brown</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mrs. Sarah Outterbridge</b>	
19. <b>E 966 X</b>		ADDRESS <b>425 E 20th St</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>LABORER</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Multiple stab wounds</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>1</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>rear of 433 E. 20th Street</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>12 17 71 m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>stabbed by unknown assailant</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1-1-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-5-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 8 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Wm C March</b>		ADDRESS <b>928 E North Ave.</b>	

VS 151-REV. 1/1/68

N 879.7





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12151</u>	
M-460 71 12151				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>John W. Miller</u>		2. DATE AND HOUR OF DEATH <u>Dec 27 1971 7:30 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>005625 Mayview Ave</u>		A. STATE <u>Md</u>		B. COUNTY <u>2641</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>APRIL 24 1882</u>		9. AGE (In years last birthday) <u>89</u>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Baking Tools</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>215-03-8070</u>		17. INFORMANT <u>Catherine Miller</u>		ADDRESS <u>Same</u>	
18. <u>440.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>circulatory failure</u> (B) <u>ASUD</u> DUE TO, OR AS A CONSEQUENCE OF: <u>normal aging</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-22</u> 19 <u>67</u> to <u>12-27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12-26</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>Richard R. Rigler</u>			
23B. DATE SIGNED <u>12-28-71</u>		23C. PHYSICIAN'S NAME (Type) <u>Von Richard R. Rigler</u>			
23D. ADDRESS <u>1 W. Overlea Ave</u>		23E. CITY OR TOWN <u>Baltimore Md</u>			
23F. STATE <u>Md</u>		23G. ZIP CODE <u>21202</u>			
23H. COUNTY <u>Harford</u>		23I. ADDRESS <u>8802 Harford Rd</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-625 71 12152				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12152	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <b>LARKINS, ELIZABETH May</b>				2. DATE AND HOUR OF DEATH <b>DECEMBER 27, 1971 4:20 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2505</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST AGNES HOSPITAL 2-16-72</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>FEMALE</b>				6. RACE <b>CAUCASION</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>10 11 07</b>		9. AGE (in years last birthday) <b>68 64</b>	
11. BIRTHPLACE (State or foreign country) <b>DELAWARE Trenton, N. J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Charles McCormick 220-68-7488</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth McCormick</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-68-7488</b>		17. INFORMANT <b>BALTIMORE MD 21229</b>		ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVE</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>(X) (this hospital)</b> attended the deceased from <b>DECEMBER 25 19 71</b> to <b>DECEMBER 27 19 71</b> that <b>(X) (we)</b> last saw the deceased alive on <b>DECEMBER 27 19 71</b> and that <b>(X) (my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X) (We)</b> (did) <b>XXXX</b> view the body after death.							
23A. SIGNATURE <b>Donato A. Vargas Jr M.D.</b>						23B. DATE SIGNED <b>12-27-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Donato A. Vargas Jr M.D.</b>				23D. ADDRESS <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVES</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/30/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland 21061</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. J. [Signature]</b>		25C. FUNERAL DIRECTOR <b>MR. Kelly</b>		ADDRESS <b>130 E. Fort Avenue</b>	

2-16-1972 - Correction form from Funeral Director and letter from The Life Insurance Company  
of Virginia, 1657 Whitehead Court, Baltimore, Md. 21207  
(signed) B. S. Finney  
Representative

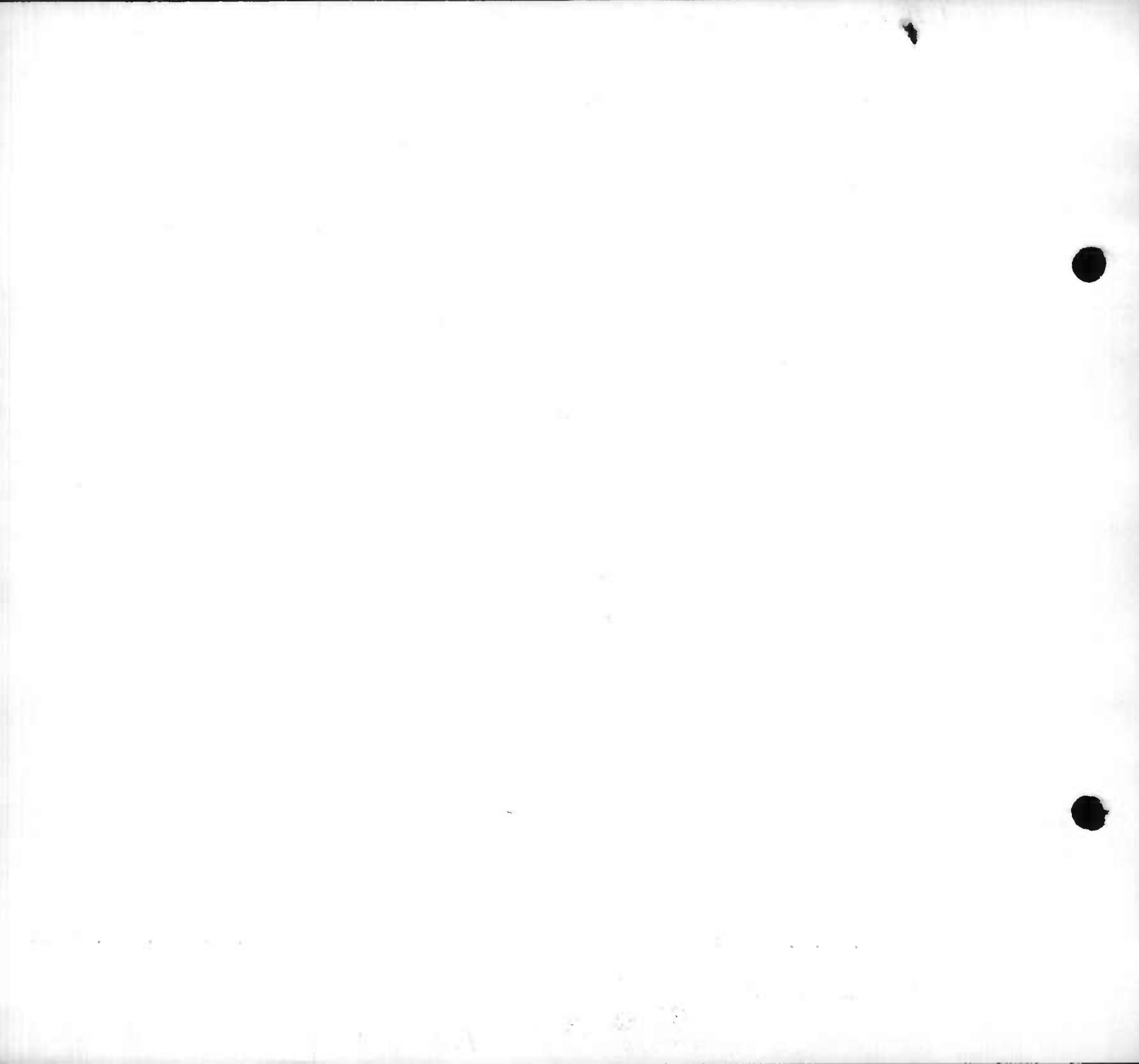
And letter from - Dept. of Health, Education & Welfare  
Social Security Administration  
Murray L. Miller, Jr.  
Claims Representative

HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

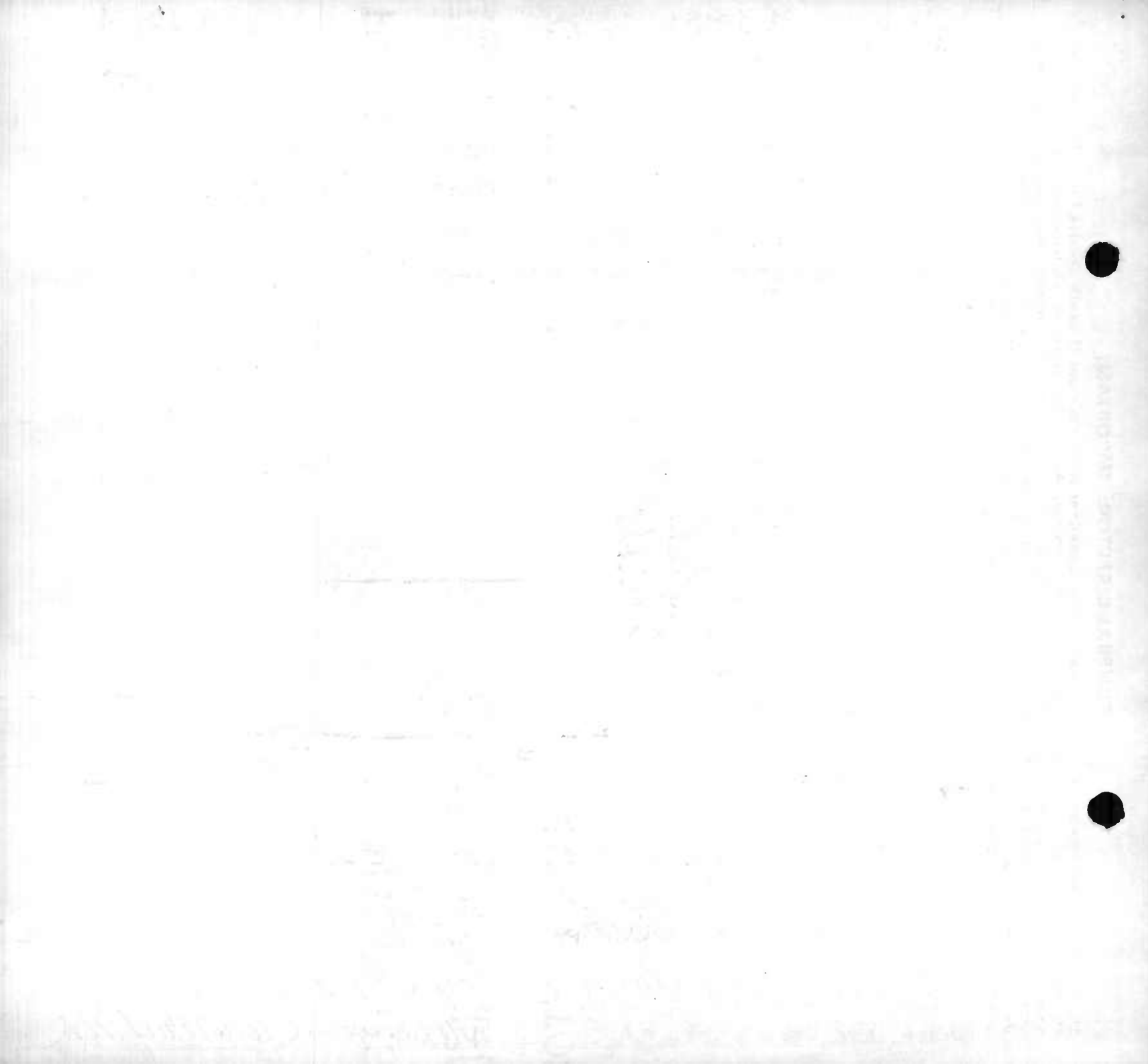
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12153</b>	
N#520 71 12153		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>IDA E. NEMEC</b>		2. DATE AND HOUR OF DEATH <b>12/29/71</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2505</b>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>SOUTH BALTO. HOSP.</b> <b>43</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presser</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SHIRT FACTORY</b>		8. DATE OF BIRTH <b>5-23-08</b> 9. AGE (In years last birthday) <b>63</b>	
13. FATHER'S NAME <b>MARTIN PRILLER</b>		14. MOTHER'S MAIDEN NAME <b>FANBACK</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>215-01-0920</b>		17. INFORMANT <b>Husband</b> ADDRESS <b>4519 Pennington</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2/12</b> 19 <b>27</b> to <b>12/29</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>11/16</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S.R. Gehlert MD</b>		23B. DATE SIGNED <b>12/30/71</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. S.R. Gehlert</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-31-71</b>		24C. NAME of CEMETERY or CREMATORY <b>HOLY CROSS</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Bease</b>		25C. FUNERAL DIRECTOR <b>HANN, FUNERAL Home</b>	
24D. LOCATION (City, town, or county) (State) <b>Ritchie Hwy BALTO. MD.</b>		25D. ADDRESS <b>4200 Pennington</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-260 71 12154		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12154	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HILDA GEIGER		12-24-71 1:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital 44				A. STATE Md. B. COUNTY BALTIMORE 2748	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5635 Ridge Ave LONGGREEN Nursing home	
5. SEX F	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-1922	9. AGE (in years last birthday) 79	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MISSOURI	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME Theodor Meyer		14. MOTHER'S MAIDEN NAME Olivia Meyer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219 34 4125		17. INFORMANT Mrs Harold Rein 5601 Jagna Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Stentosis AS CVD (B) DUE TO, OR AS A CONSEQUENCE OF: Ex R femur (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION		MEDICAL EXAMINER'S SIGNATURE			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) H.H.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1577 Hillman Ave	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) H 2:00 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-28-71 to 12-24-71 that (I) (we) last saw the deceased alive on 12-24-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. J. Helou, M.D.				23B. DATE SIGNED 12-24-71	
23C. PHYSICIAN'S NAME (Type) A. J. HELOU, M.D.				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/28/71		24C. NAME of CEMETERY or CREMATORY Parkwood Cem	
24D. LOCATION Baltimore		24E. CITY, town, or county Baltimore		24F. STATE Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Helou		25C. FUNERAL DIRECTOR W. J. Helou 6607 Half Rd	





BIRTH NO.		REG. NO.	
M-424		71 12155	
BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Charles F. Malcolm, Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 21 Year 71 Hour 10:03A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month 12 Day 21 Year 71 Hour 10:03A.M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
7. RACE White		C. CITY OR TOWN Baltimore	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH April 12, 1920		E. STREET AND NUMBER 1412 Jeffers Road	
10. AGE (In years lost birthday) 51		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles F. Malcolm, Sr.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		14B. KIND OF BUSINESS OR INDUSTRY Public Service Comm.	
15. MOTHER'S MAIDEN NAME Dorothea Kaloes		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No None	
17. SOCIAL SECURITY NO.		18. INFORMANT Family records	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Craniocerebral injuries DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) bridge		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Frederick Rd. bridge over Beltway	
22D. TIME OF INJURY (APPROX.) 12 21 71 9:50A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? jumped from bridge to Beltway		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-21-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE Dec. 24, 1971	
24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 8 1972		25B. NAME OF REGISTRAR John Burns, Sons, Towson, Maryland	
25C. FUNERAL DIRECTOR John Burns, Sons, Towson, Maryland		ADDRESS	

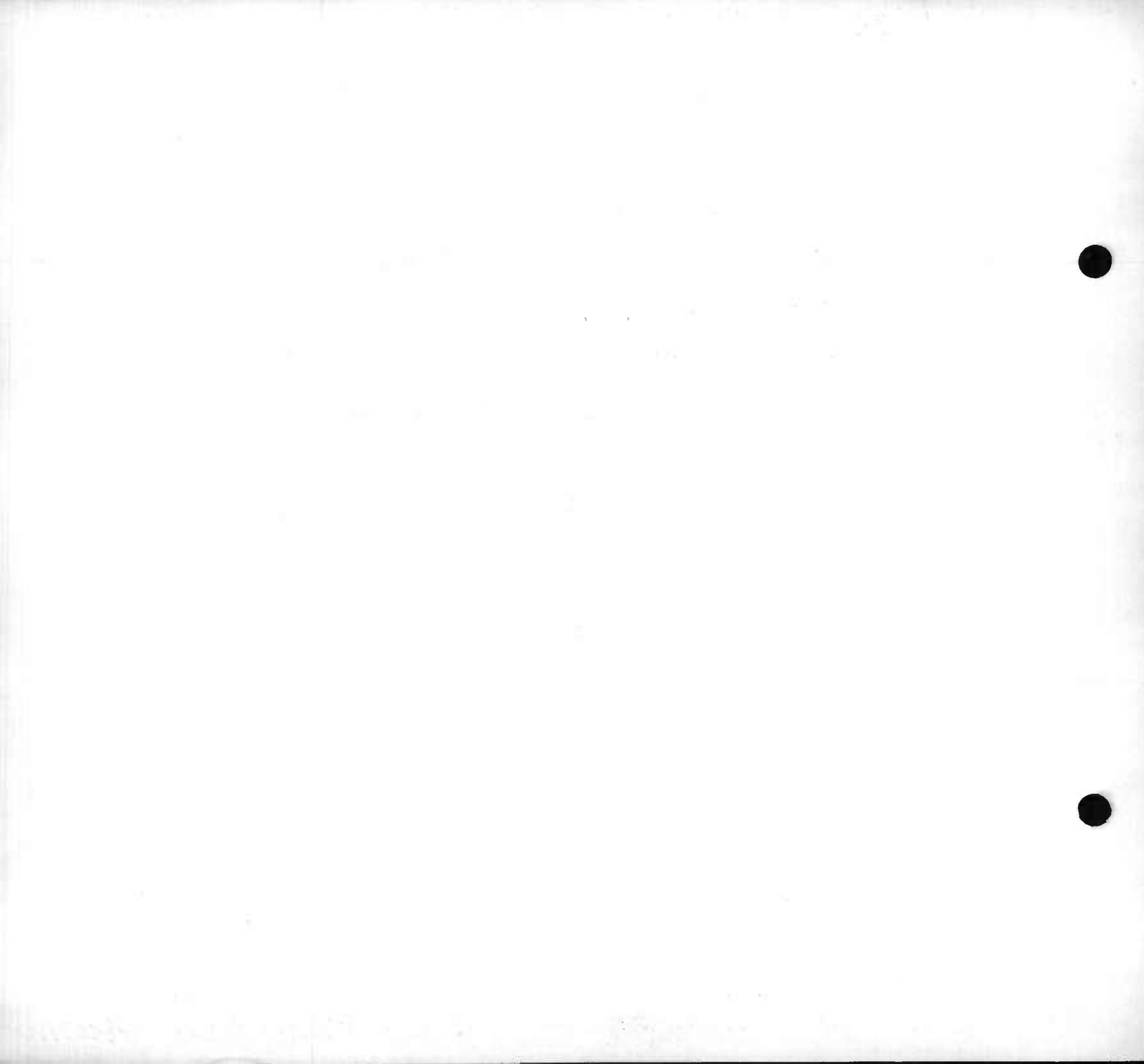
Page 1



FUNERAL DIRECTOR: IMPORTANT

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<p><b>C-630 71 12156</b></p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>		<p><b>71 12156</b></p> <p>REG. NO.</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>James Crotty</u></p>		<p>2. DATE AND HOUR OF DEATH <u>12/22/71 2:45 AM</u></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION <u>Good Samaritan Hospital</u></p> <p>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>579 Valley View Road</u></p>	
<p>5. SEX <u>Male</u></p>	<p>6. RACE <u>White</u></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>5/4/12</u></p> <p>9. AGE (in years last birthday) <u>59</u></p> <p>II Under 1 Yr. Months Days III Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Food Technologist</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>Can Mfg. Co.</u></p>	
<p>11. BIRTHPLACE (State or foreign country) <u>Maryland</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>	
<p>13. FATHER'S NAME <u>James F. Crotty</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Mary E. Kelly</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><u>No</u> <u>None</u></p>		<p>16. SOCIAL SECURITY NO. <u>215-10-2334</u></p>	<p>17. INFORMANT <u>Family records</u></p>
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>(A) IMMEDIATE CAUSE <u>SEPSIS</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF: <u>PNEUMONIA FISTULA</u></p> <p>(B) <u>SEUDOMONAS PNEUMONIA</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF: <u>Poly Myositis</u></p> <p>(C) <u>Bleeds</u></p>	
<p>19A. DATE OF OPERATION <u>12/22/71</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>11/30</u> 19 <u>71</u> to <u>12/22</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/22</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>Robert P. Jacobs</u></p>		<p>23B. DATE SIGNED <u>12/22/71</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>ROBERT P. JACOBS, M.D.</u></p>		<p>23D. ADDRESS <u>GSA, BALT, MD</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>Dec. 24, 1971</u></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u></p>		<p>25B. NAME OF REGISTRAR <u>John J. Brown</u></p>	
<p>25C. FUNERAL DIRECTOR <u>John J. Brown</u></p>		<p>ADDRESS <u>John J. Brown</u></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City and County				BALTIMORE CITY AND COUNTY				Registered No.			
M-46071 12157				CERTIFICATE OF DEATH				71 12157			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
Minnie B. Miller				12/30/71				10 A			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE				B. COUNTY			
(If not in hospital or institution, give street address or location)				Md				2864			
90 General German Aged Peoples Home				C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore			
22 S. Athol Avenue				D. STREET ADDRESS (If rural, give location)				22 S. Athol Avenue			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. Under 1 Yr. Months Days	
female		white		widowed		9/20/1877		94			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Housewife								Germany			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
				Gottlieb Powolskin (late)				Charlotte Powolskin (late)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
				217-54-0687				22 S. Athol Avenue 21229			
				General German Aged Peoples Home							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO				Cardio Respiratory Failure			
ANTECEDENT CAUSES				(B) DUE TO				Malnutrition + Dehydration			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO				Carcinoma of Vagina			
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from June 1971 to 30 Dec 1971, that (I) (we) lost saw the deceased alive on 30 Dec 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
William J. Bryson				30 Dec 71							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
W J. Bryson				5772 Westview Mall. Balt Md							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)					
Burial		1/4/72		Woodlawn Cemetery		Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
JAN 3 1972				Ress, J. E.				Witzke 51630 Edmondson Ave., 21228			

Adm. to N.H. 10/59.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12158</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>S-530</b></span> <span><b>71 12158</b></span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)			
		<b>SMITH, EDWARD ROBERT (Schmidt)</b>			
2. DATE AND HOUR OF DEATH		<b>DECEMBER 31, 1971 1:30 A. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST AGNES HOSPITAL CATON &amp; WILKENS AVENUES BALTIMORE, MARYLAND 21229</b>		A. STATE		B. COUNTY	
		<b>MARYLAND</b>		<b>BALTIMORE</b>	
		21207			
C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
<b>BALTIMORE</b>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER		2014 DERRICKSON ROAD <b>5300</b>			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<b>MALE</b>	<b>CAUCASIAN</b>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>01/09/19</b>	<b>52</b>	<b>letter carrier</b>
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>POSTAL</b>		<b>MARYLAND</b>		<b>U.S.A.</b>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<b>PHILIP SMITH</b>			<b>ISABELLE MACKINNON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<b>YES</b>		<b>W W 2</b>		<b>BALTO MD 21229</b>	
		<b>218-05-3674</b>		<b>ST AGNES' RECORDS CATON &amp; WILKENS AVES</b>	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>I</b>            DISEASE OR CONDITION DIRECTLY LEADING TO DEATH            (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b>            DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.         </div> <div style="width: 50%;">           (A) IMMEDIATE CAUSE  <b>CARCINOMA RECTUM</b>            DUE TO, OR AS A CONSEQUENCE OF:  <b>ABO &amp; LIVER METASTASES - ASCITES</b>            (B) DUE TO, OR AS A CONSEQUENCE OF:            (C)         </div> <div style="width: 10%; text-align: center;">           APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <b>2 YRS</b>  <b>6 MOS</b> </div> </div>					
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<b>09/5/69</b>		<b>CARCINOMA RECTUM</b>		<b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
I APPROX.		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from <b>DECEMBER 30</b> 19 <b>71</b> to <b>DECEMBER 31</b> 19 <b>71</b> that (X) (we) last saw the deceased alive on <b>DECEMBER 31</b> 19 <b>71</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<b>Robert E. Healy M.D.</b>				<b>12/31/71</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<b>ROBERT E. HEALY M.D.</b>		<b>3350 WILKENS AVENUE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<b>Burial</b>		<b>1/4/72</b>		<b>Lorraine Park</b>	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
<b>Woodlawn, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<b>JAN 8 1972</b>		<b>Robert E. Healy, M.D.</b>		<b>Witzke, 51630 Edmondson Ave. 21228</b>	

*[Faint, mostly illegible text covering the majority of the page, appearing to be a document or report.]*

RECEIVED DIRECTOR'S OFFICE



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">71 12159</span>	
<div style="display: flex; justify-content: space-between;"> <span>D-100 71 12159</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
DUFF, James		845 AM 12/30/71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
33 The Johns Hopkins Hospital		Maryland Howard 6300			
5. SEX		6. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		12/22/09		62	
7. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country)	
Cauc.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Maryland	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY	
Vice Pres. & Mgr		Md. Music Corp		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
James A Duff (Late)		Mary Elizabeth Glennon (Late)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		215-09-1358		Ellicott City, Md. Mrs. Patricia Duff, Beechwood Road Rt 1	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
569.31		(A) IMMEDIATE CAUSE Multiple abscess + Enter-cutaneous fistula			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
8/02/71		Villous adenoma Colon		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12/26/71 19 to 12/30/71 19 that (I) (we) last saw the deceased alive on 12/30/71 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
N. M. Hansen, M.D.		12/30/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
N. M. Hansen, M.D.		The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1/3/72		Mount Olivet	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 3 1972		Witzke, 5630 Edmondson Ave., 21228			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">71 12160</span>
T-400 BIRTH NO. <span style="float: right;">71 12160</span>		1. NAME OF DECEASED (Type or Print) <span style="float: right;">ANNA TULLY</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <span style="float: right;">12/31/71 12:44 P.M.</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">SINAL HOSPITAL OF BALTIMORE</span>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="float: right;">MD</span> B. COUNTY <span style="float: right;">PLEASANT</span>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <span style="float: right;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <span style="float: right;">PARK HEIGHTS 2834</span>		
5. SEX <span style="float: right;">F</span>	6. RACE <span style="float: right;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">3/1/06</span>	9. AGE (In years last birthday) <span style="float: right;">65</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">RETIRED</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="float: right;">U.S.A.</span>
12. CITIZEN OF WHAT COUNTRY <span style="float: right;">USA</span>		13. FATHER'S NAME <span style="float: right;">N.A.</span>		
14. MOTHER'S MAIDEN NAME <span style="float: right;">N.A.</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <span style="float: right;">215-36-3058</span>		17. INFORMANT <span style="float: right;">Mrs. Brian Tully</span>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="float: right;">PULMONARY EDEMA.</span> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="float: right;">DIABETIC COMA. DIABETES MELLITUS. KETOSIDOSIS.</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="float: right;">12 HRS. 15+ yrs.</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <span style="float: right;">2 NONE</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="float: right;">—</span>		20A. AUTOPSY? (Yes or No) <span style="float: right;">YES</span>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <span style="float: right;">NO</span>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="float: right;">P.A.</span>		21C. WHERE DID INJURY OCCUR? <span style="float: right;">P.A.</span>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <span style="float: right;">N.A.</span>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <span style="float: right;">NOVEMBER 7</span> 19 <span style="float: right;">71</span> to <span style="float: right;">DECEMBER 31</span> 19 <span style="float: right;">71</span> that (1) (we) last saw the deceased alive on <span style="float: right;">DECEMBER 31</span> 19 <span style="float: right;">71</span> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="float: right;">T. Concepcion M.D.</span>		23B. DATE SIGNED <span style="float: right;">1/1/72</span>		23C. PHYSICIAN'S NAME (Type) <span style="float: right;">T. CONCEPCION M.D.</span>
23D. ADDRESS <span style="float: right;">3502 W. ROGERS AVE. 21215</span>		24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		
24B. DATE <span style="float: right;">1/5/72</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="float: right;">New Cathedral</span>		24D. LOCATION (City, town, or county) (State) <span style="float: right;">Baltimore, Maryland</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">JAN 3 1972</span>		25B. NAME OF REGISTRAR <span style="float: right;">Robert E. Tully</span>		25C. FUNERAL DIRECTOR <span style="float: right;">Witzke, 1630 Edmondson Avenue 21228</span>

9/24/71 - Adm. to N.H.

814 Stamford Rd. 21229

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 12161	
B-634 71 12161				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BORDLEY JOSEPHINE		12.28.71 8:10P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 39 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital 2600 Liberty Hgts. Baltimore, Md.			Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4101 Rogers Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	November 25, 1967	75	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Unemployed				Stevensville, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			216-18-2680		
17. INFORMANT			ADDRESS		
Madeline Brockington (Daughter)			Same		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest					
(B) AS.C.V.D. I. CHF DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month (Day) (Year) (Hour) (Approx))		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12.28.71 to 12.28.71 that (I) (we) last saw the deceased alive on 12.28.71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
R. Mitra				12.28.71.	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DR R.C. MITRA. MD.				Provident Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		1/2/72		STEVENSVILLE CEMETERY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 3 1972		Robert F. Barber, R.D.		MARY E. HOWE. 802 Madison Ave.	

Stevensonville, Pa.

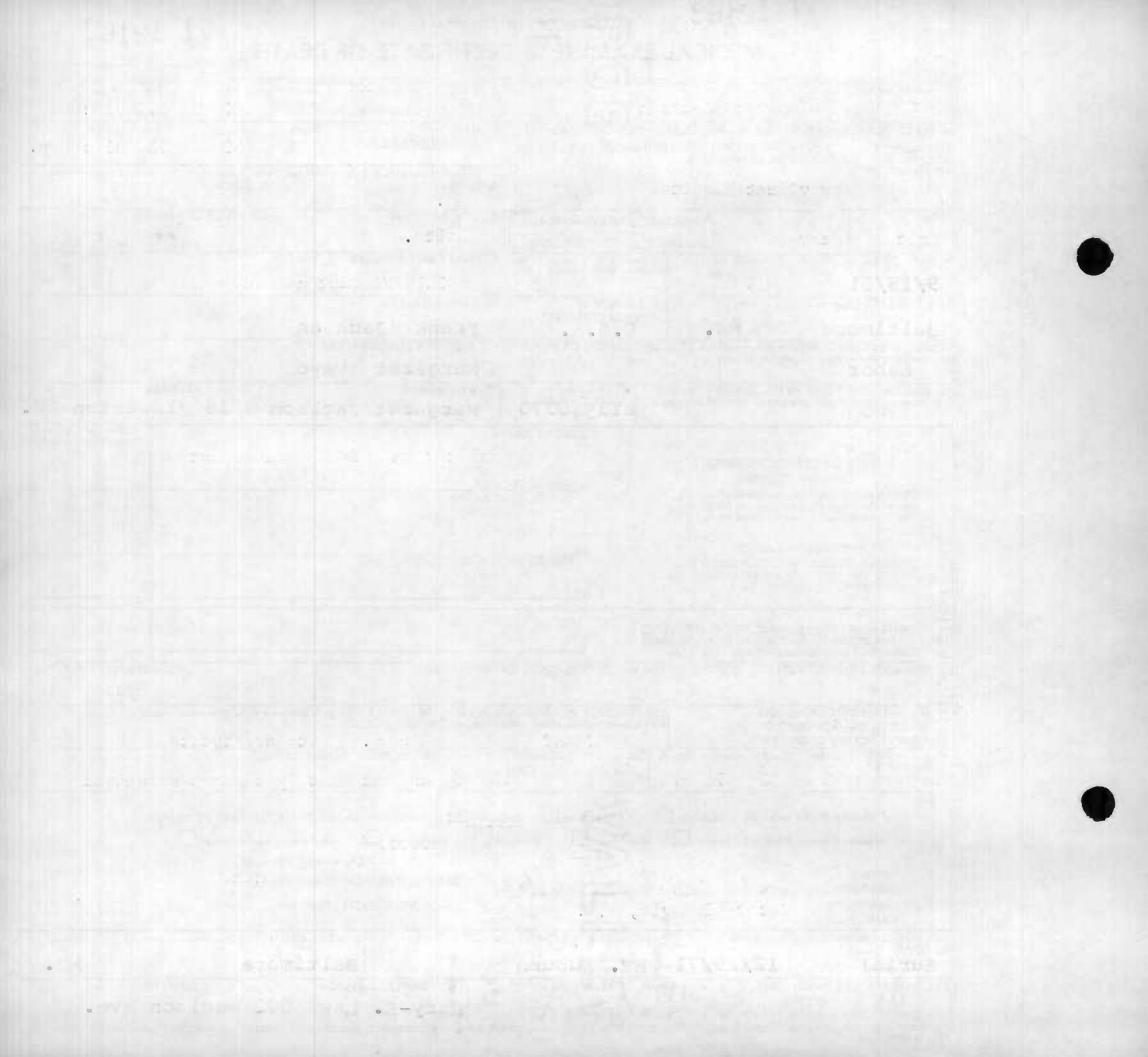
Stevensonville, Pa.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edward Jackson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 23 71 10:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 23 71 10:00 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1608			
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
9. DATE OF BIRTH 9/18/51		10. AGE (In years last birthday) 20	E. STREET AND NUMBER 3816 Flowerton Road
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Frank Jackson
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Margaret Mayo
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 213540770	18. INFORMANT ADDRESS Margaret Jackson 3816 Flowerton Rd.
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E965X Gunshot wound of head and chest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET Penna. & Pitcher Streets	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Penna. & Pitcher Streets		22F. HOW DID INJURY OCCUR? Subject shot by unknown assailant	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 12 23 71 ? m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/29/71	
24C. NAME OF CEMETERY or CREMATORY MT. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore MD.	
25A. DATE REC'D BY HEALTH DEPT JAN 8 1972		25B. NAME OF REGISTRAR Mary-E. Law	
25C. FUNERAL DIRECTOR Mary-E. Law		ADDRESS 802 Madison Ave.	

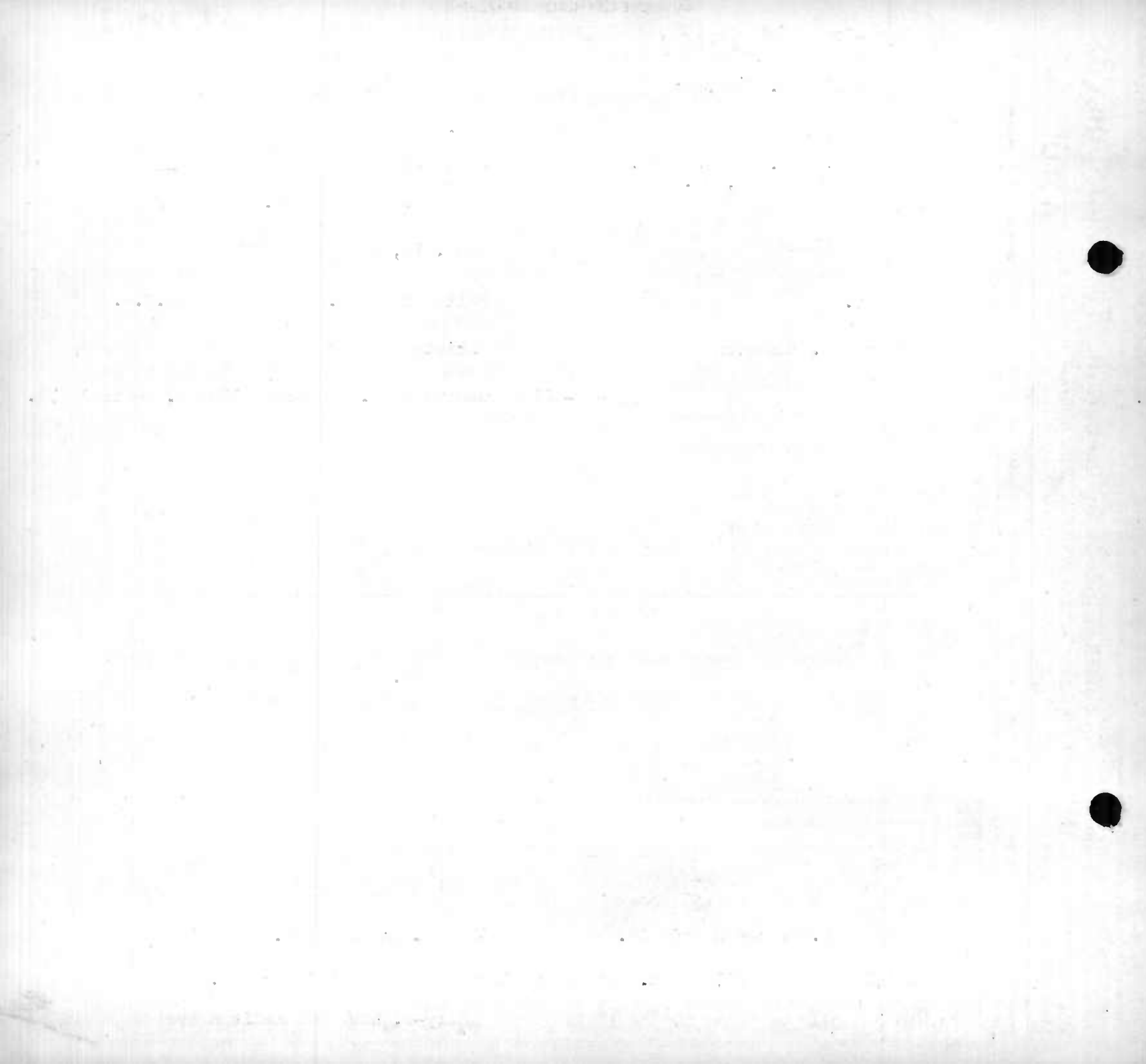




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12163</b>	
T-512 71 12163		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Charles R. Thompson</b>		2. DATE AND HOUR OF DEATH <b>12/ 27/ 71</b> <b>730</b> P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1001</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> <b>1204 N. Central Ave. Baltimore, MD.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>1204 N. Central Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 18, 94</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Oliver J. Thompson</b>			
14. MOTHER'S MAIDEN NAME <b>Arista Jones</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>218-10-1513</b>		17. INFORMANT <b>Genevieve M. Thompson</b> ADDRESS <b>1204 N. Central AVE.</b>			
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchogenic Carcinoma</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO.</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/1 1971</b> to <b>12/27 1971</b> , that (I) (we) last saw the deceased alive on <b>12/27 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. Bernard Harris JR.</b>		23B. DATE SIGNED <b>12/30/71</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Bernard Harris JR.</b>	
23D. ADDRESS <b>1200 N. McCulloh st.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>12/31/71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Mary-E. Law</b>		25C. FUNERAL DIRECTOR <b>802 Madison Ave</b>	



J-525

W-42571 12164

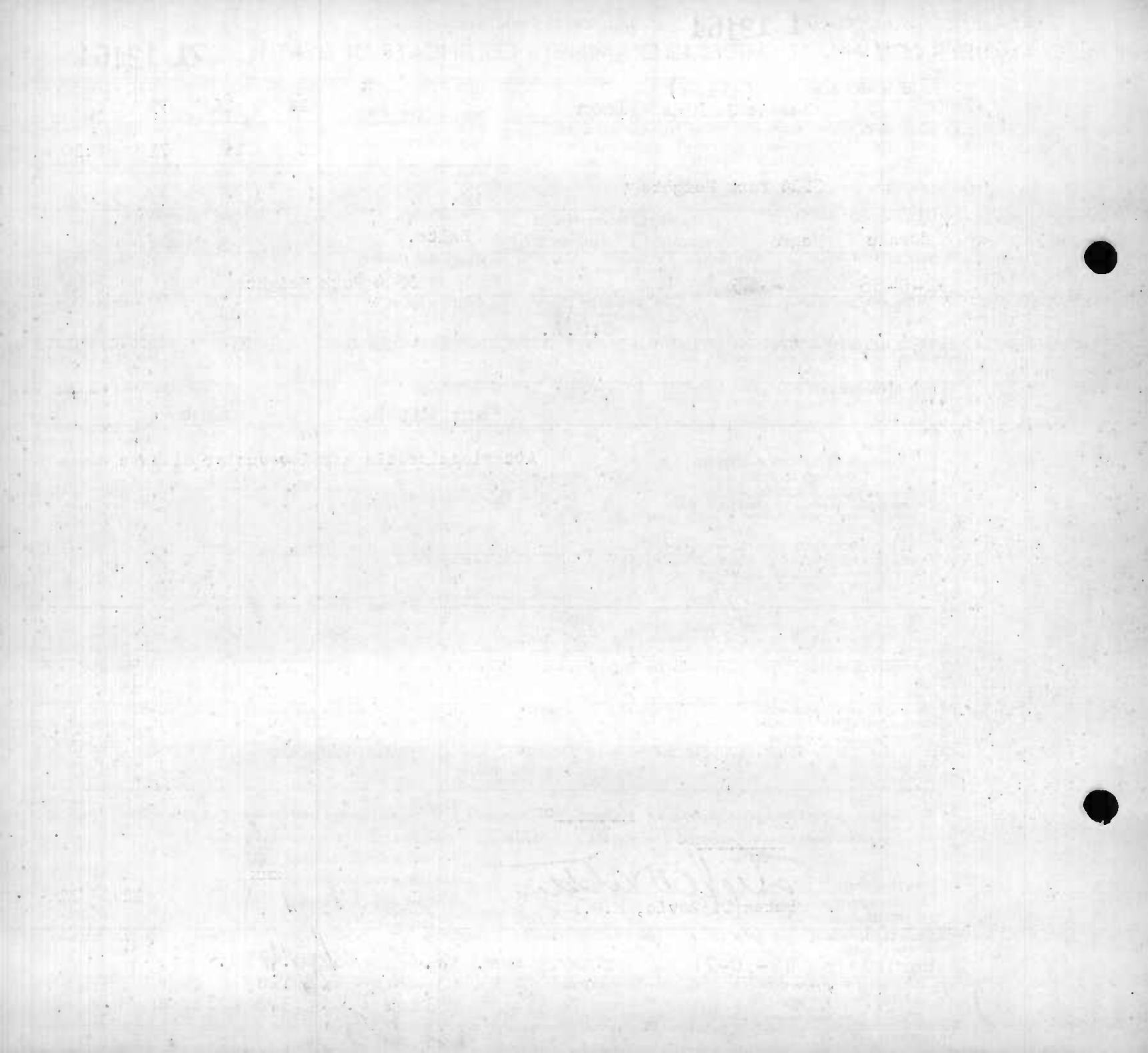
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12164

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Bessie Jenkins Wilson</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>12</b> Day <b>26</b> Year <b>71</b> Hour <b>M.</b> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3524 Park Heights</b>		3. DATE PRONOUNCED DEAD Month <b>12</b> Day <b>26</b> Year <b>71</b> Hour <b>8:30 a.m.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1512</b>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>female</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>12-5-86</b>	10. AGE (In years lost birthday) <b>85</b>	E. STREET AND NUMBER <b>3524 Park Heights</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mary Mitchell</b>		ADDRESS <b>same</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>12/26/71</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>W. Bailey</b>		ADDRESS <b>Kelson F.H. 1348 Calhoun St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 12165</u>	
M-324 71 12165		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MITCHELL, THOMAS</u>		2. DATE AND HOUR OF DEATH <u>12/28/71 at 8:20 p.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1538</u>	
5. SEX <u>M</u>		6. RACE <u>NEGRO</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-5-79</u>	
9. AGE (In years last birthday) <u>92</u>		10. If Under 1 Yr. Months Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>JAMICA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MARGUERITE BROWN 2114 Division St.</u>		ADDRESS	
18. <u>427.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>with Congestive Cardiac Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>probable pulmonary infection</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>12-31-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/15/71</u> to <u>12/28/71</u> that (I) (we) last saw the deceased alive on <u>12/28/71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Anjana Doshi M.D.</u>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>ANJANA DOSHI M.D.</u>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-31-71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey, M.D.</u>	
25C. FUNERAL DIRECTOR <u>V. BAILEY</u>		ADDRESS <u>1348 Calhoun St.</u>	

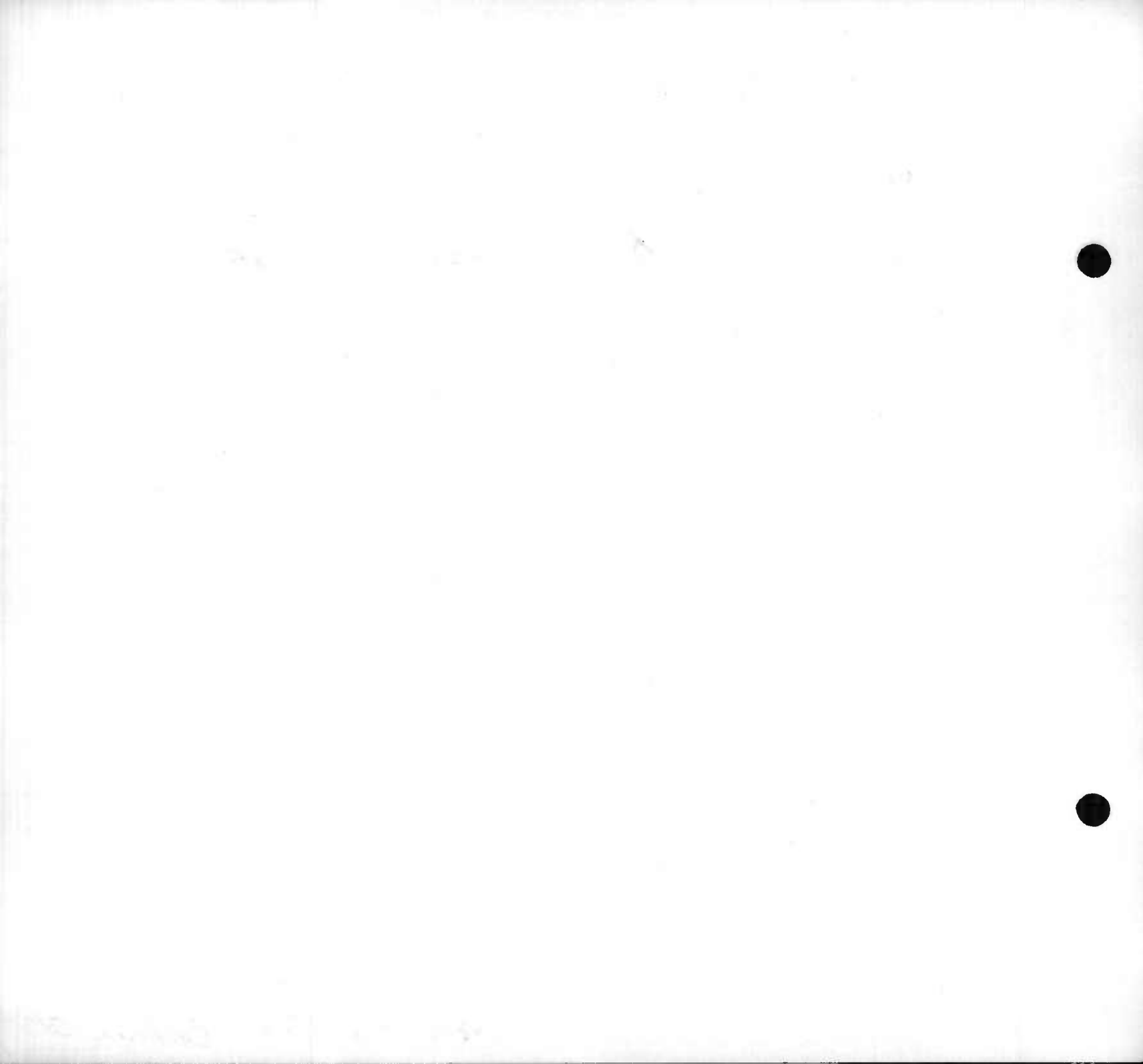
11/8/71 Adm.

Had been in a number  
of Institutions prior  
to this.

# FUNERAL DIRECTOR: IMPORTANT

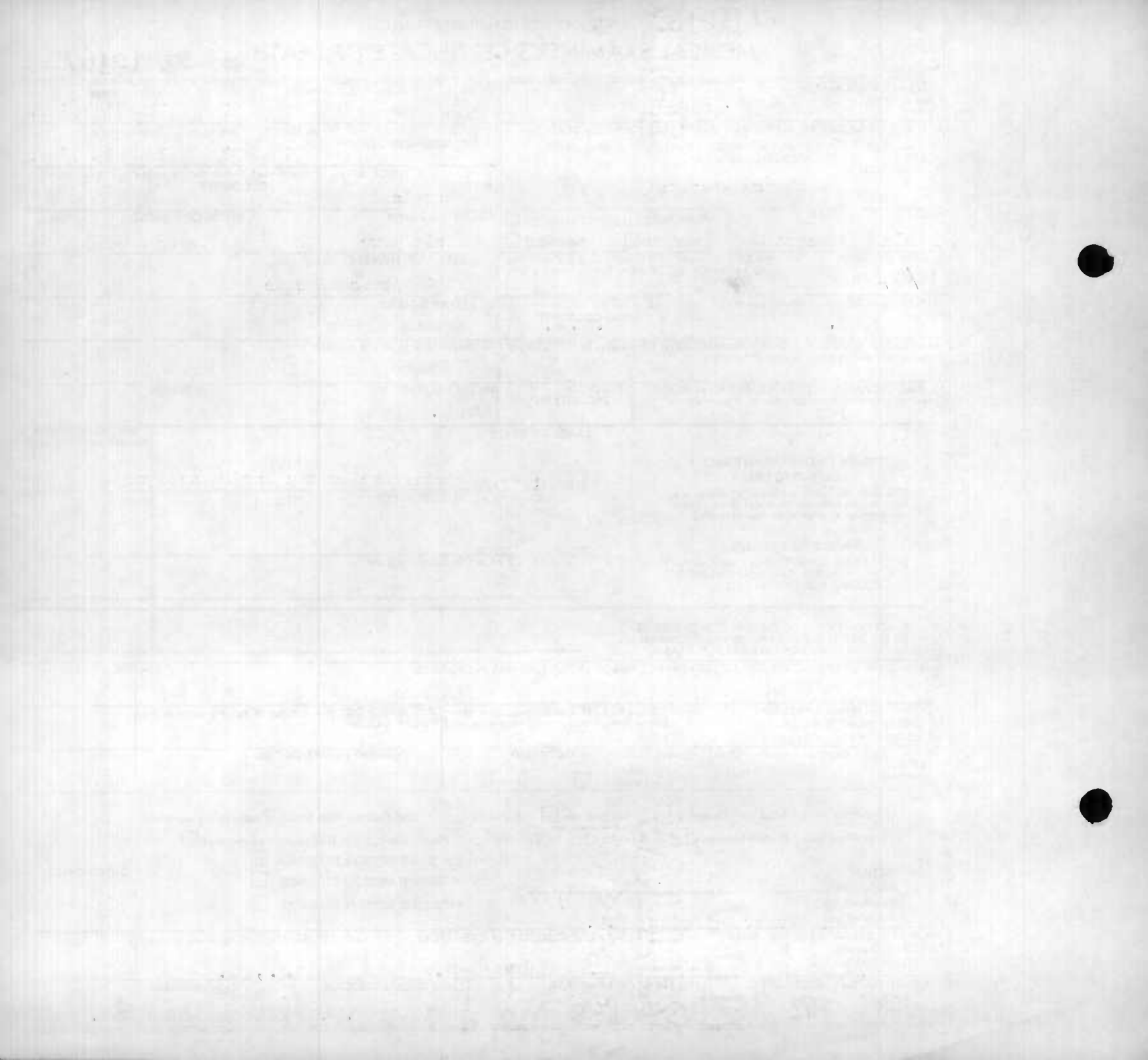
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12166</u>	
BIRTH NO. <u>D-500 71 12166</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>THOMAS H. DUNAWAY</u>			2. DATE AND HOUR OF DEATH <u>12/28/71 1925 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIV. Md. Hosp.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>ST. 402</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>605 W. Lexington St.</u>		
5. SEX <u>M</u>	6. RACE <u>B</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-8-86</u>	9. AGE (In years last birthday) <u>85</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>THOMAS Dunaway</u>			14. MOTHER'S MAIDEN NAME <u>HELENE Conway</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>ROBERTA DUNAWAY</u> ADDRESS <u>SAME</u>	
18. <u>731.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <u>CARDIO-RESPIRATORY FAILURE</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>BRAIN STEM COMPRESSION</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>INTRATEMP. LOBE HEMATOMA</u> (C) <u>?</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS.</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>12/27/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Temp. lobe hematoma</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nally medical examined) <u>?</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> 19 <u>71</u> to <u>12/28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph Soliman M.D.</u> DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH SOLIMAN M.D.</u> DEGREE				23D. ADDRESS <u>UNIV Md. Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-4-73</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>1348 Calhoun St</u>	





BIRTH NO.		REG. NO.	
G-650		71 12167	
1. NAME OF DECEASED (Type or Print) John W. Green		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 27 Year 71 Hour 12:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month 12 Day 27 Year 71 Hour 12:45 P.M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1606	
7. RACE Negro		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 2946 Arunah Avenue	
9. DATE OF BIRTH 10/22/94		10. AGE (In years last birthday) 76	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leman Green		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Annie Morrall		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Robt. Green ADDRESS same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular DUE TO, OR AS A CONSEQUENCE OF: disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-28-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun St.	



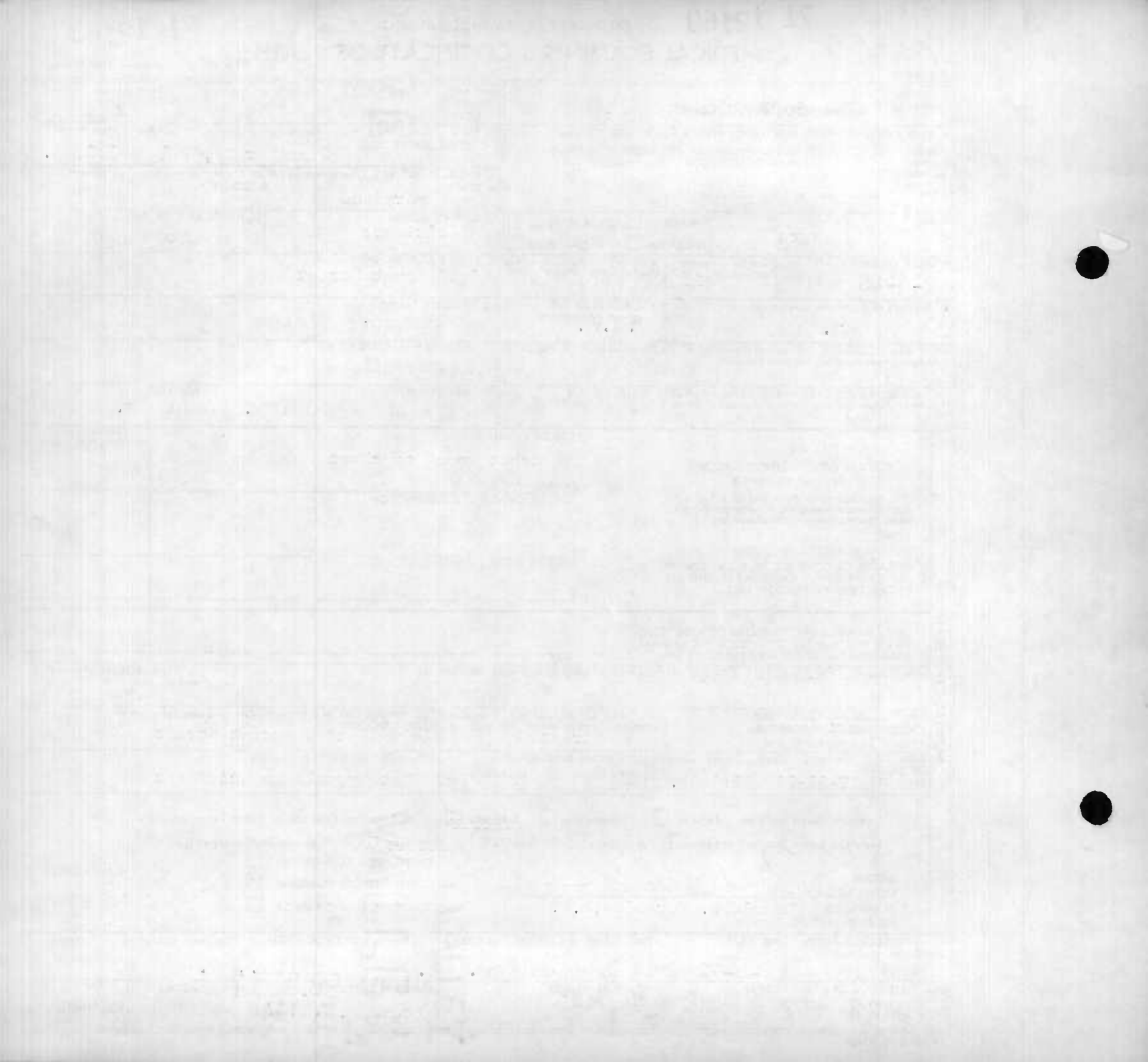
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 12168	
CERTIFICATE OF DEATH				REG. NO. _____	
BIRTH NO. <u>W 232</u>		DATE AND HOUR OF DEATH <u>7:45 AM 12-27-71</u>			
1. NAME OF DECEASED (Type or Print) <u>MARY C. Henderson (Westcott)</u>		2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1547</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 3019 Poplar Terrace Baltimore 21216</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>Neg</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>Nov 7, 1895</u> 9. AGE (In years last birthday) <u>75 yr</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Woodson</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-30-20410</u>	
17. INFORMANT <u>Mrs Marylene Schreiber</u>		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Bladder</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Heart Disease, atherosclerosis</u>		20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Bladder</u>		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Hypertension - arteriosclerosis</u>	
19A. DATE OF OPERATION <u>Dec 20</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 19, 1971</u> to <u>Dec 27, 1971</u> that (I) (we) last saw the deceased alive on <u>Dec 19, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>G. E. Kingston MD</u>		23B. DATE SIGNED <u>12/27/71</u>		23C. PHYSICIAN'S NAME (Type) <u>G. E. Kingston MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12-20-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Park</u>	
24D. LOCATION (City, town, or county) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>R. E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Kellogg F. H.</u>		25D. ADDRESS <u>1348 Calhoun St</u>		25E. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>	



1		71 12169		BALTIMORE CITY HEALTH DEPARTMENT		71 12169	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.	
1. NAME OF DECEASED (Type or Print) Theodore Anthony Alston				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour December 29, 1971 7:35 A. M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9-6-46				10. AGE (in years lost birthday) 25		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF U.S.A.				13. FATHER'S NAME Theodore Alston		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1603	
15. MOTHER'S MAIDEN NAME t helma King				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			
17. SOCIAL SECURITY NO.				18. INFORMANT ADDRESS Dora King 1041 N. Mount St.			
19. E 965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes				22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1000 Block Whatcoat Street 1602			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-11-71 11:10 P. m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR? Shot by unknown assailant				23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/29/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1-4-72			
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.				24D. LOCATION (City, town, or county) (State) Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972				25B. NAME OF REGISTRAR Robert E. Bailey, M.D.			
25C. FUNERAL DIRECTOR Kelson F.H. 1348				ADDRESS Calhoun Street			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-263 71 12170		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12170	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>NETTIE RICHARDSON</b>		2. DATE AND HOUR OF DEATH <b>12/31/71 6<sup>10</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Belair Nursing Home</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>Md.</b> B. COUNTY <b>1001</b>	
5. SEX <b>F.</b>		6. RACE <b>B.</b>		C. CITY OR TOWN <b>Balto.</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 10, 95</b>		9. AGE (In years past birthday) <b>76</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>	
13. FATHER'S NAME <b>ALISON LYNCH</b>		14. MOTHER'S MAIDEN NAME <b>Adeline Mills</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Sadie Taylor - 1012 E. Biddle St.</b>	
18. <b>412.3 I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) <b>SYSTEMIC SCLEROSIS; RHEUMATOID ARTHRITIS</b> <b>ESOPHAGEAL STRICTURE; CATARACTS</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/2/71</b> to <b>12/31/71</b> that (I) (we) last saw the deceased alive on <b>12/31/71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Alvin B. Brasher</b>				23B. DATE SIGNED <b>12/31/71</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<b>Removal</b>		<b>1-4-72</b>		<b>Enfield, N. Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>JAN 3 1972</b>		<b>Robert E. Taylor, M.D.</b>		<b>Barth J. Clifton - 1129 N. Carolina</b>	





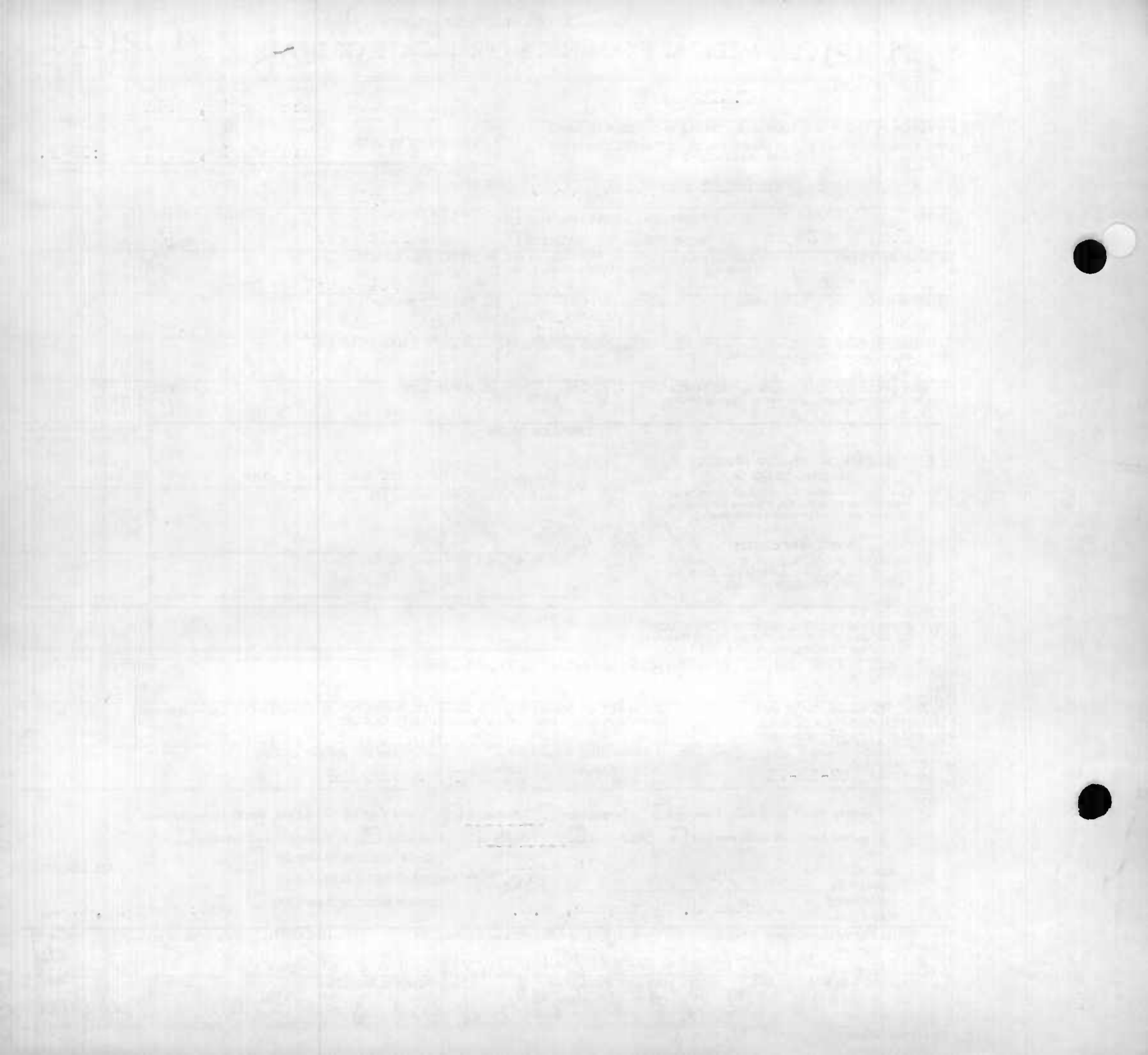
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12171

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIE BAKER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 29, 1971		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year December 29, 1971		Hour 4:35 P. M.
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH 5-5-17		10. AGE (In years lost birthday) 54		11. BIRTHPLACE (State or foreign country) S. C.
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Roy Williams		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2733
15. MOTHER'S MAIDEN NAME M. T. Baker		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		17. SOCIAL SECURITY NO.
18. INFORMANT Fairmean Baker-4701 Catalpha Rd.		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 4901 Catalpha Road 2733
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-29-71		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot self
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 30, 1971
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-4-72		24C. NAME OF CEMETERY or CREMATORY Md. National Mem. PK.
24D. LOCATION (City, town, or county) (State) Laurel, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR E. Taylor, M.D.
25C. FUNERAL DIRECTOR Frank S. Clark		25D. ADDRESS 11297 Caroline		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

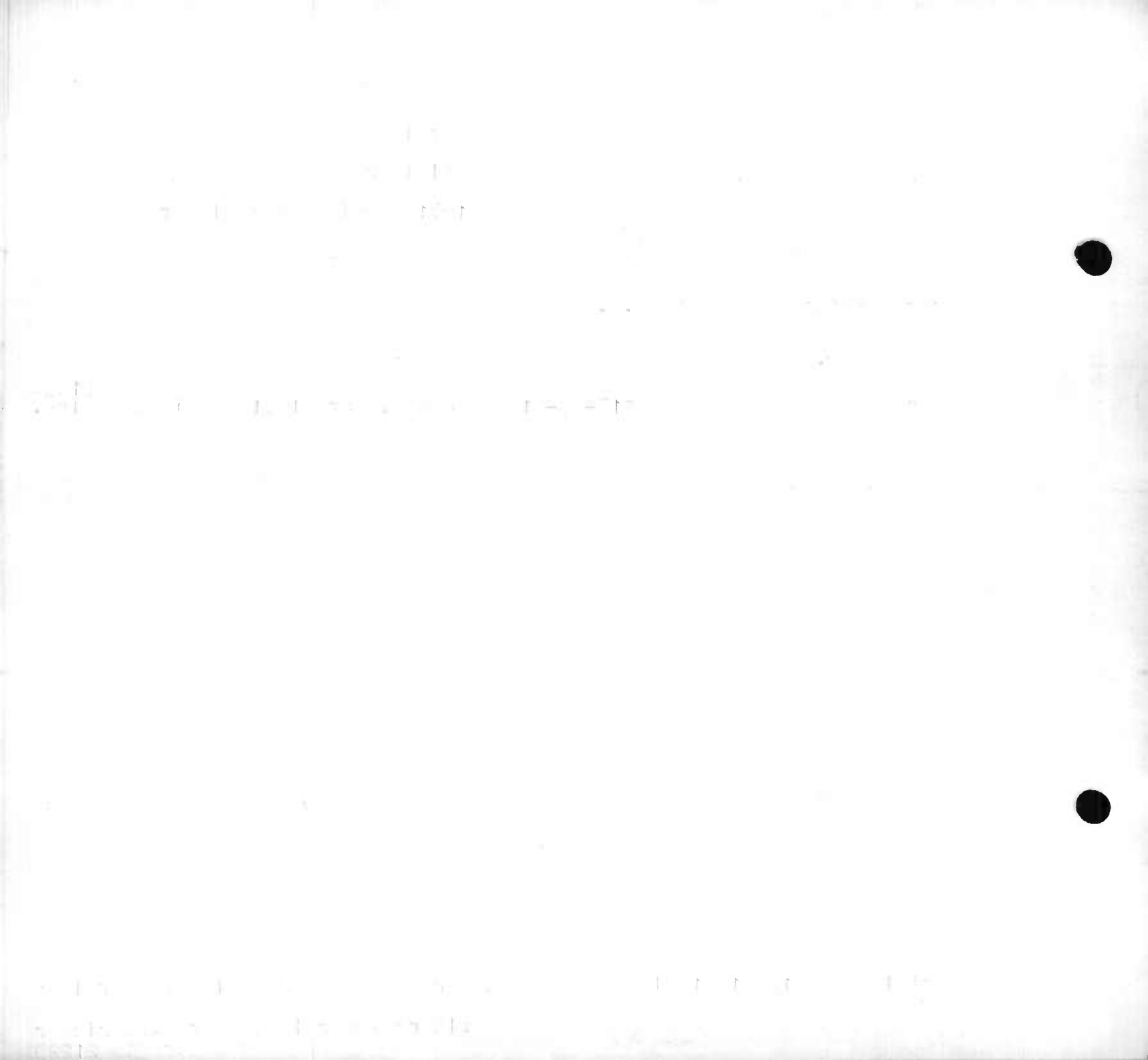
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12172</u>	
71 12172				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>SIMMONS JUANITA</u>		2. DATE AND HOUR OF DEATH <u>12-31-71</u> <u>11:00 PM.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>905</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital of Maryland</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>C N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KING OF BUSINESS OR INDUSTRY <u>Good man Construction</u>		8. DATE OF BIRTH <u>Oct. 17 1930</u> 9. AGE (In years last birthday) <u>41 yr</u>	
11. BIRTHPLACE (State or foreign country) <u>N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Archie McLean</u>	
14. MOTHER'S MAIDEN NAME <u>Victoria Oden</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS			
18. <u>430.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebral Haemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertension?</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> (C) <u>Myocardial Infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-26-1971</u> to <u>12-31-1971</u> that (I) (we) last saw the deceased alive on <u>12-31-1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Abdul Majid Memon M.D.</u>		23B. DATE SIGNED <u>1-1-72</u>		23C. PHYSICIAN'S NAME (Type) <u>ABDUL MAJID MEMON M.D.</u>	
23D. ADDRESS <u>730 Ashburton St. Baltimore Md 21216</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>1-3-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT. Calvary Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Brooklyn, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Gaber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Clifford O. Wilson</u>	
ADDRESS		ADDRESS			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-630 71 12173				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12173	
1. NAME OF DECEASED (Type or Print) <u>John S. Ward</u>				2. DATE AND HOUR OF DEATH <u>12/28/71</u> <u>17:40</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u> <u>38</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>2102</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1271 Washington Boulevard</u>			
5. SEX <u>m</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/5/01</u>	9. AGE (in years last birthday) <u>70</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Yard Master</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George F. Ward</u>				14. MOTHER'S MAIDEN NAME <u>Maude D. McCauley</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05-5188A</u>		17. INFORMANT <u>Anna M. Ward</u>		ADDRESS <u>21230 1271 Washington Blvd.</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiogenic Shock</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute MI</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiogenic Shock</u> (B) <u>Acute MI</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>CVA</u>				<u>10 days</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <u>Dec 20</u> 19 <u>70</u> to <u>Dec 28</u> 19 <u>71</u> that (H) (we) last saw the deceased alive on <u>Dec 28</u> 19 <u>71</u> and that (H) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Richard A. Tomasulo M.D.</u>				23B. DATE SIGNED <u>12/28/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Richard Tomasulo</u>	
23D. ADDRESS <u>Univ. of Maryland Hosp., Balt., Md.</u>				23E. DEGREE <u>DEGREE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/31/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Jones, M.D.</u>		25C. FUNERAL DIRECTOR <u>Walters Funeral Home</u>			
				ADDRESS <u>Pratt &amp; Stricker Streets 21223</u>			

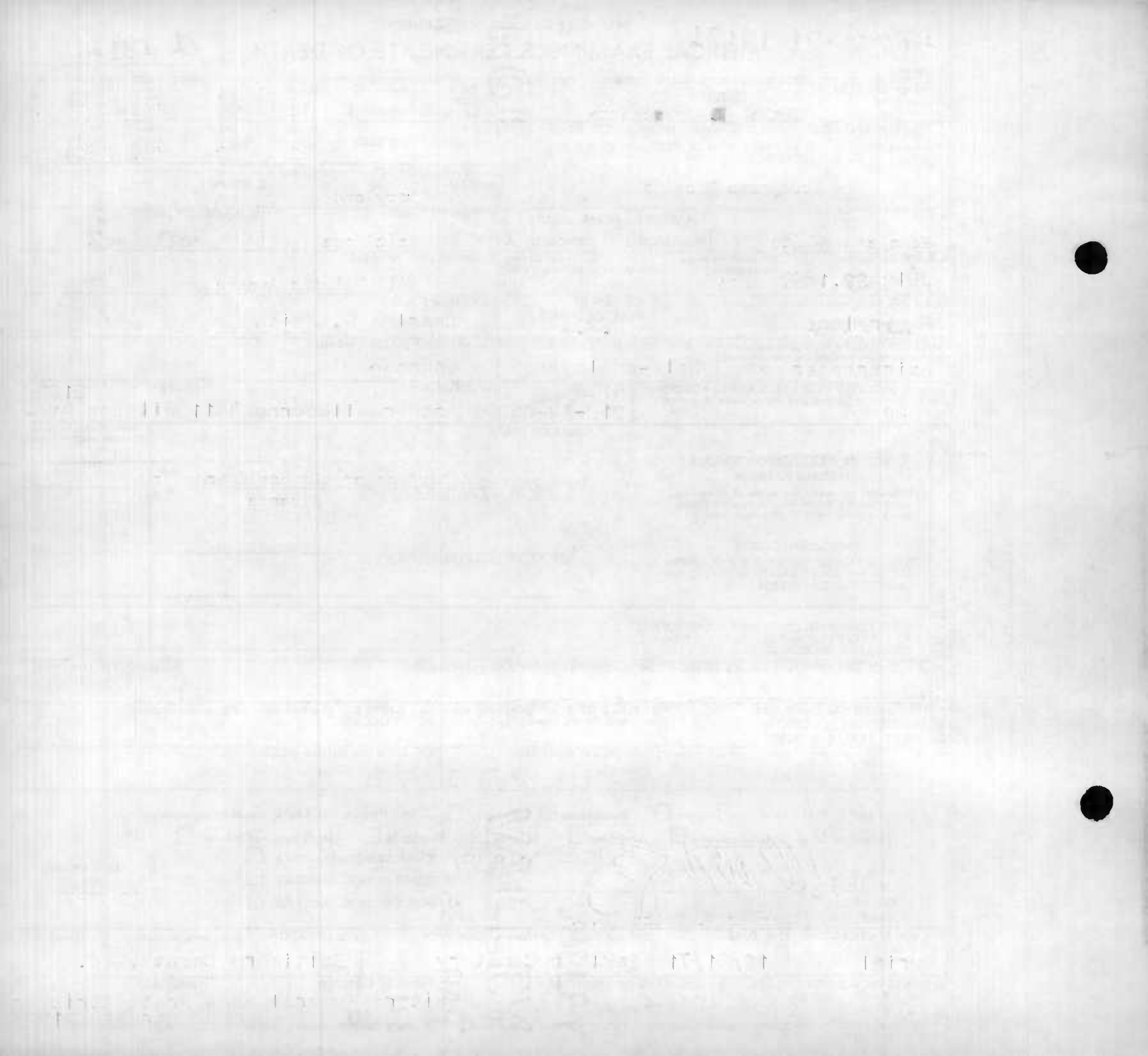


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mae Ethel Frechette		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 27 Year 71 Hour 7:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month 12 Day 27 Year 71 Hour 7:30 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH July 22, 1897		10. AGE (In years last birthday) 74	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hairdresser		14B. KIND OF BUSINESS OR INDUSTRY Self-employed	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 219-32-062	
15. MOTHER'S MAIDEN NAME Unknown		18. INFORMANT 21229 Arthur Kilbourne	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 12-28-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/71	
24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR R. B. Taylor, M.D.	
25C. FUNERAL DIRECTOR Walters Funeral Home		ADDRESS Pratt & Stricker Streets 21223	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 12175	
T-460 71 12175		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Eva B. Tyler		2. DATE AND HOUR OF DEATH 12/27/71 1:30 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED/DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
Baltimore City Hospital 4940 Eastern Avenue, Baltimore, Maryland		Md. Baltimore 5300			
5. SEX Female		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 4-30-00	
housewife				9. AGE (In years last birthday) 71	
13. FATHER'S NAME Henry Smearman		14. MOTHER'S MAIDEN NAME Barbara Tresh		11. BIRTHPLACE (State or foreign country) Md.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-54-1454		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Edema		30 / un	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Coronary heart disease		years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,		(C) Pericardial aneurysm		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White <input type="checkbox"/> Not White <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3:30 am 12/27/19 71 to 4:30 am 12/27/19 71 and that (I) (we) last saw the deceased alive on 4:00 am 12/27/19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michele Codina M.D.				23B. DATE SIGNED 12/27/71	
23C. PHYSICIAN'S NAME (Type) Michele Codina				23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/71		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR John J. Duda	
ADDRESS 7922 Wise Ave. Dundalk, Md.					

1870-1871

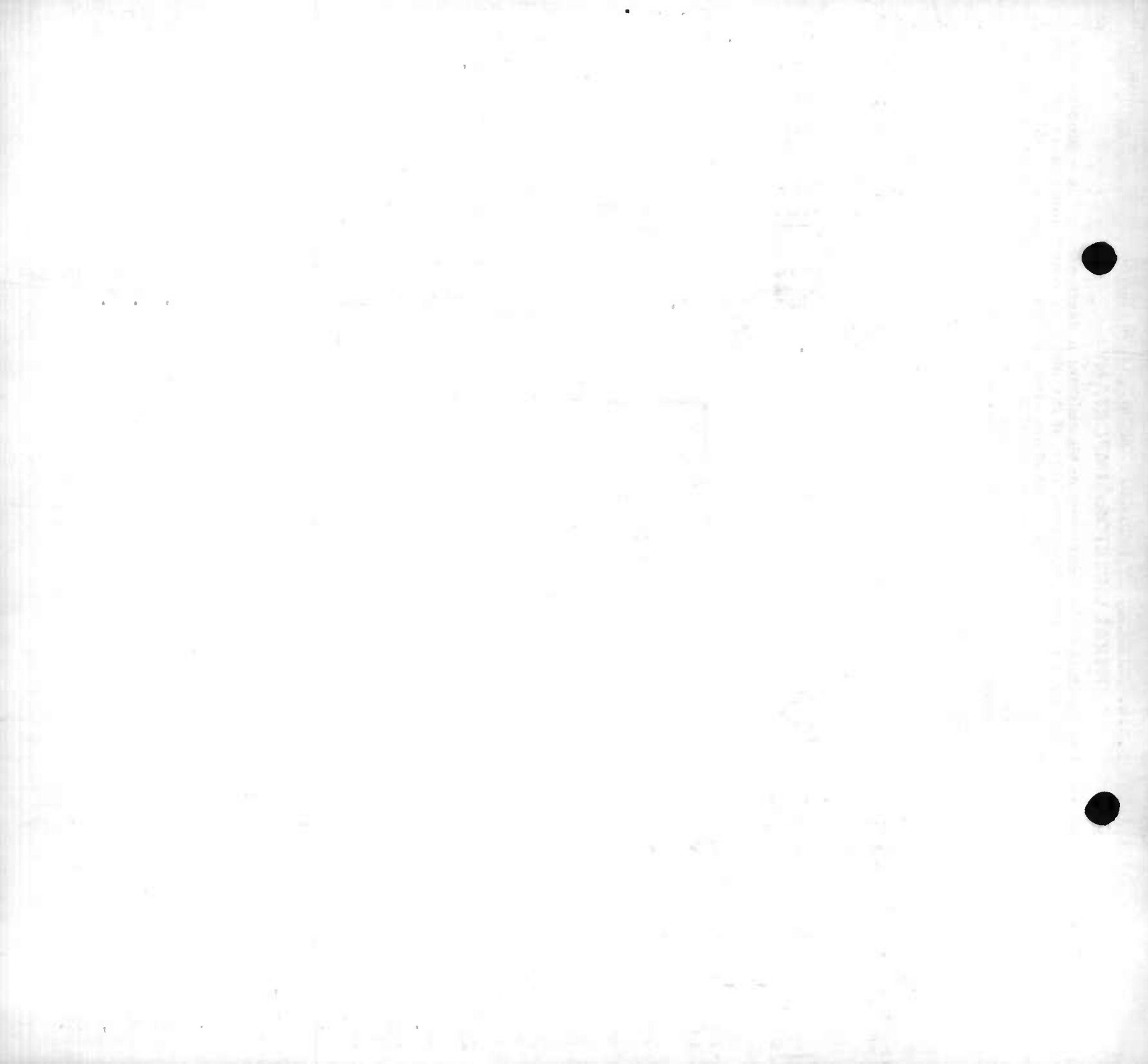
1871-1872

## FUNERAL DIRECTOR: IMPORTANT

36-88-18 djr

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
H-435		71 12176		71 12176	
1. NAME OF DECEASED (Type or Print)		KERNAL HELTON Kernal M. Helton		2. DATE AND HOUR OF DEATH DECEMBER 27, 1971 12.05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, or institution residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. CITY OR TOWN Dundalk	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 7720 Fairgreen Road 21222	
6. SEX Male	7. RACE Caucasian	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 4-29-10	10. AGE (in years last birthday) 61	11. BIRTHPLACE (State or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Benjamin J. Helton		14. MOTHER'S MAIDEN NAME Frances Disney	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 405-03-8238		17. INFORMANT BCH: RECORDS Baltimore, Maryland 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 Hour	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		21. DUE TO, OR AS A CONSEQUENCE OF: Disease		Years	
22. I certify that (1) (this hospital) attended the deceased from March 27 1963 to December 27 1971, that (1) (we) last saw the deceased alive on December 27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James Yeung, M.D.		23B. DATE SIGNED 12/27 71		23C. PHYSICIAN'S NAME (Type) James Yeung, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-71		24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens	
24D. LOCATION Bel Air, Maryland		24E. DATE REC'D BY HEALTH DEPT. JAN 3 1972		24F. NAME OF REGISTRAR Robert F. Taylor, Jr.	
24G. FUNERAL DIRECTOR John J. Duda		24H. ADDRESS 7922 Wise Ave. Dundalk, Md.		24I. DATE 12/27 71	



## CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)NORMAN MCKINNEY  
Norman McKinney

2. DATE AND HOUR OF DEATH

12/30/71

4:45 AM

12/30/71

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

3300 Liberty Parkway 21222

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8-25-03

9. AGE (in years  
last birthday)

68

11. Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired - Supt. of Apartments

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charlie McKinney

14. MOTHER'S MAIDEN NAME

Easter Hughes

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)  
No16. SOCIAL  
SECURITY NO.

246-14-3845A

17. INFORMANT

BCH-Records

ADDRESS

4940 Eastern Avenue

Baltimore, Maryland 21224

18.

410-91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia  
Brain Damage 2° Anoxia

(B) DUE TO, OR AS A CONSEQUENCE OF:

2° Cardiac Arrest 2°

(C) DUE TO, OR AS A CONSEQUENCE OF:

Paroxysmal Acute Myocardial Infarction 11 days  
by Atrial FibrillationAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

4 days

11 days

11 days

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (Infile medical examined)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-19-71 19 to 12-30-71 19

that (I) (we) last saw the deceased alive on 12-29-71 19 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

W. L. Ramseur MD

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12/30/71

23C. PHYSICIAN'S  
NAME (Type)

W. L. Ramseur MD

DEGREE

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal-Burial

24B. DATE

1/2/72

24C. NAME OF CEMETERY OR CREMATORY

Pittman Cemetery

24D. LOCATION

(City, town, or county)

(State)

Spruce Pine, Mitchell Co., N. C.

25A. DATE REC'D BY HEALTH DEPT.

JAN 3 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

John J. Duda

ADDRESS

7922 Wise Ave. Dundalk, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

How to make a ...

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400		71 12178		BALTIMORE CITY HEALTH DEPARTMENT		+ REG. NO. 71 12178	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Hall, James Leroy</u>			
2. DATE AND HOUR OF DEATH <u>12/28/71</u> <u>3:35 a.m.</u>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)				A. STATE <u>MARYLAND</u> B. COUNTY <u>HOWARD</u>			
C. CITY OR TOWN <u>COLUMBIA</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>5433 WOLF RIVER LAKE</u>				6300			
5. SEX <u>M</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/8/92</u>	
9. AGE (in years last birthday) <u>79</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MD. CASUALTY</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RICHARD L. HALL</u>				14. MOTHER'S MAIDEN NAME <u>CARTER, Emma</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>318-10-5958</u>		17. INFORMANT <u>CHART</u> ADDRESS	
18. <u>560.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH <u>Small intestinal obstruction</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Abdominal adhesion</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>day</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore, City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>December 27, 1971</u> to <u>Dec 28, 1971</u> that (I) (we) last saw the deceased alive on <u>Dec 28, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Thien Thiti Varana</u> M.D. DEGREE				23B. DATE SIGNED <u>Dec 28, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>THIEN THITIVARANA</u> M.D. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-31-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ARBUTUS MEMORIAL PARK</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>John E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Arby &amp; Phillips Funeral Home</u>		ADDRESS <u>1727 N. Monroe St.</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 12179	
M-200 71 12179				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>MASSEY, Gabriel</i>		2. DATE AND HOUR OF DEATH <i>12-30-71 9:19 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1504</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hsopital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>2009 McKean Avenue</i>	
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 9, 1911</i>		9. AGE (In years last birthday) <i>60</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	
13. FATHER'S NAME <i>Hidia Massey</i>				14. MOTHER'S MAIDEN NAME <i>Janie Bush</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>246-18-7975</i>		17. INFORMANT <i>Edna Massey 2009 McKean AVXnue</i>	
18. <i>250.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Pre-renal failure.</i>				<i>3 days.</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12-29</i> 19 <i>71</i> to <i>12-30</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>12-30</i> 19 <i>71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED <i>12-30-71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Mandour</i>				23D. ADDRESS <i>S. H. at Baltimore</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-4-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1972</i>			
25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>William S. Phillips 1727 N. Monroe Street</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 12180	
J-525 BIRTH NO. 71 12180		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHNSON E. ROSALIND		2. DATE AND HOUR OF DEATH 12/25/71 8:50 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL 42 OF BALTO		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTO C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5411 PRICE AVE			
5. SEX FEM.	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/50	9. AGE (In years last birthday) 21	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIDE, PROVIDENT HOSP		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Raymond Johnson		14. MOTHER'S MAIDEN NAME Eva Palmer		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-58-8540		17. INFORMANT Raymond Johnson 2708 Chelsea Ave	
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral vascular accident (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11/13/71	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/24 1971 to 12/25 1971 that (I) (we) last saw the deceased alive on 12/25 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D. DEGREE				23B. DATE SIGNED 12/25/71	
23C. PHYSICIAN'S NAME (Type) DAVID GLASER, M.D. DEGREE				23D. ADDRESS SINAI HOSP. OF BALTO.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-71		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore Md.		24E. DATE REC'D BY HEALTH DEPT. JAN 8 1972		24F. NAME OF REGISTRAR [Signature]	
24G. FUNERAL DIRECTOR [Signature]		24H. ADDRESS 1727 M. Monroe St.		24I. [Signature]	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

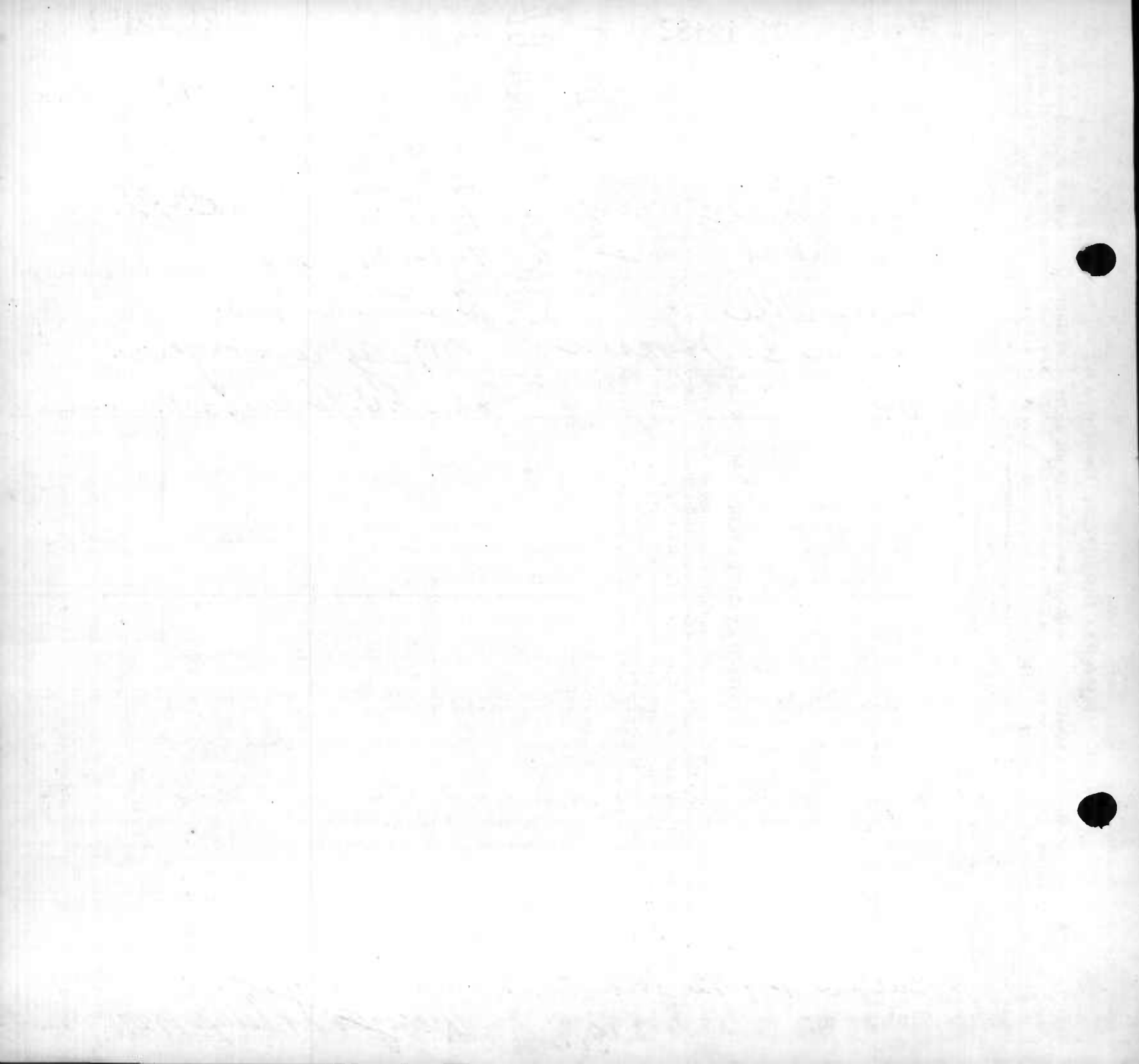
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12181</u>	
BIRTH NO. <u>5-250</u>		71 12181		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <u>Shirley V. Jackson</u>			2. DATE AND HOUR OF DEATH <u>12-25-71</u> <u>11 PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hospital</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>2543</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>2641 HUON ST</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>FEMALE</u>			6. RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>09/ 07 37</u>	
13. FATHER'S NAME <u>Charles, John</u>		14. MOTHER'S MAIDEN NAME <u>CLINKSCALES, ELIZABETH</u>		9. AGE (In years last birthday) <u>34</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-32-8407</u>		17. INFORMANT <u>Robert Jackson</u>	
18. <u>014X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <u>Hypovolemia + Shock</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Gastrointestinal Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>? Tuberculosis</u>  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Sarcoidosis</u>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>		19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>12-1-</u> 19 <u>71</u> to <u>12-25-</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12-25-</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <u>Neil R. Miller, MD</u>			23B. DATE SIGNED <u>12-25-71</u>		23C. PHYSICIAN'S NAME (Type) <u>NEIL R. MILLER, MD</u>
23D. ADDRESS <u>Johns Hopkins Hospital</u>			24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>12-30-71</u>			24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary</u>		
24D. LOCATION <u>A.A. Co. Md.</u>			25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		
25B. NAME OF REGISTRAR <u>Robert E. Fisher, Jr.</u>			25C. FUNERAL DIRECTOR <u>William B. Phillips</u>		
25D. ADDRESS <u>1727 N. Mount St.</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 12182	
H-200 71 12182		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Grace Evelyn Hayes		12-29-1971 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
4013 Calbarne Rd. Baltimore, Maryland				Maryland 1608	
5. SEX		6. RACE		C. CITY OR TOWN	
Female		Colored		Baltimore	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		D. INSIDE CITY LIMITS?	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7-1-1911		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER	
House Wife				4013 Calbarne Rd.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years lost birthday)	
John C. Hynson		Mary A. Taylor		69	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				John F. Hayes 630 N. Avenue 4th	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 hr.	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		2 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12-28 1971 to 12-29 1971, that (I) (we) last saw the deceased alive on 12-29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
G. Franklin Phillips M.D.				12/31/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
G. Franklin Phillips M.D.				558 N. Market St. Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-4-72		Arbutus Mem. Ch. Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 3 1972		Robert E. Hayes		William S. Phillips 1727 N. Market St.	

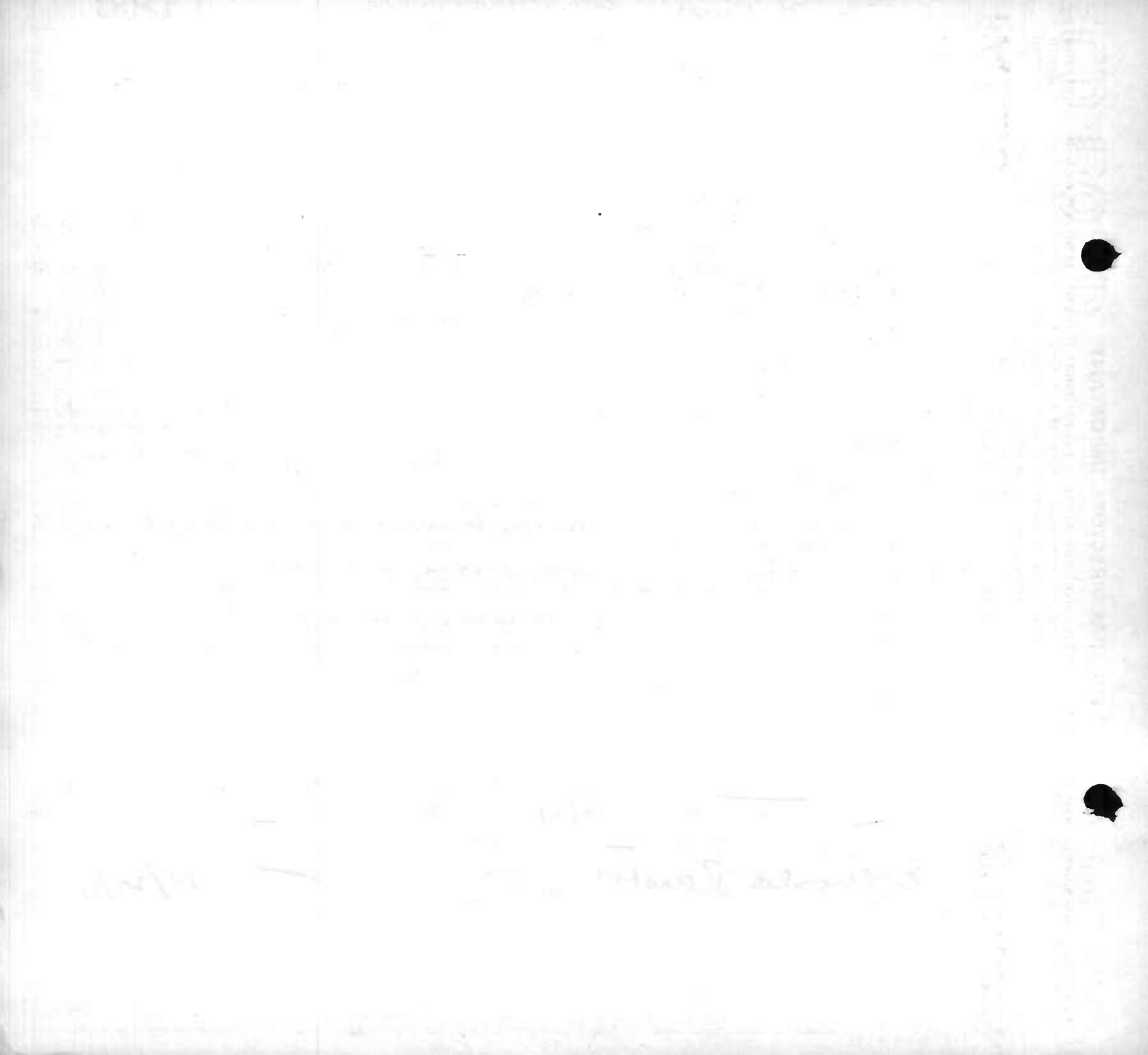




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				71 12183	
6-635 71 12183 D-530				REG. NO.	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>H arold Gordon</b>			2. DATE AND HOUR OF DEATH <b>12-29-71 3:00 P M</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital, Inc.</b>			A. STATE <b>Maryland</b> B. COUNTY <b>1502</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>1631 Appleton St.</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-16-19</b>	9. AGE (In years last birthday) <b>52</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sanitor</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Commercial Credit</b>		11. BIRTHPLACE (State or foreign country) <b>1502</b>
12. CITIZEN OF WHAT COUNTRY? <b>1502</b>					
13. FATHER'S NAME <b>William Dent</b>			14. MOTHER'S MAIDEN NAME <b>Bessie Brooks</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b>			16. SOCIAL SECURITY NO. <b>215-12-8587</b>		17. INFORMANT <b>BESSIE DENT</b>
ADDRESS <b>1634 N. APPLETON STREET</b>					
18. <b>402X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF: <b>with cerebral Hemiation</b> (B) <b>mesencephalic Intracerebral Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive Heart Disease</b> (C) <b>Aspiration Pneumonia (?)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> <b>7 days (?)</b> <b>?</b> <b>2 days</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) 1 (Month) 2 (Day) 3 (Year) 4 (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>12/28</b> 19 <b>71</b> to <b>12/29</b> 19 <b>71</b> that (I) (we) lost saw the deceased alive on <b>12/29</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Eduardo P. Ramos</b>			23B. DATE SIGNED <b>12/29/71</b>		
23C. PHYSICIAN'S NAME (Type) <b>Eduardo P. Ramos</b>			23D. ADDRESS <b>Arlington S. Phillips-1727 N. Monroe St-21217</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>1-3-72</b>	24C. NAME of CEMETERY or CREMATORY <b>MD NATIONAL MEMORIAL PARK</b>	
24D. LOCATION <b>LAUREL, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>			25B. NAME OF REGISTRAR <b>Phyllis S. Phillips</b>		
25C. FUNERAL DIRECTOR <b>Arlington S. Phillips</b>			ADDRESS <b>1727 N. Monroe St-21217</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

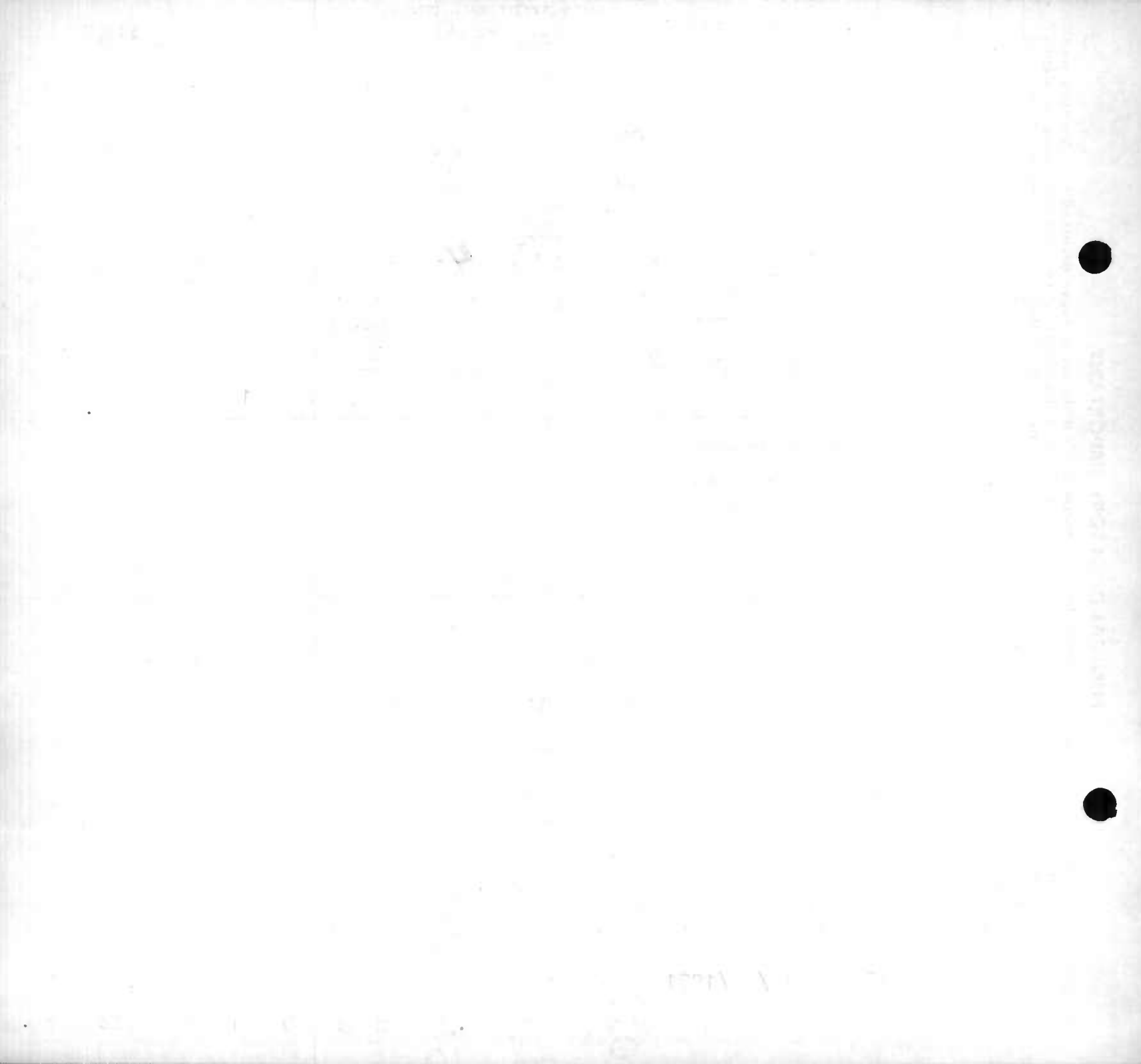
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12184</u>	
D-635 71 12184				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>DRAYTON James</u>		2. DATE AND HOUR OF DEATH <u>12-28-71</u> <u>11:00 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1502</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Swain Hospital of Baltimore</u> <u>Belvedere Av. at Greenspring</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired from Penna R.R.</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>08/03/07</u> 9. AGE (in years last birthday) <u>64</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Willie J. Drayton</u>		ADDRESS <u>1717 N. Meade St.</u>		18. <u>E 887X</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>cardiac arrest - failure to respond to pace-maker</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>probable</u> (C) <u>(R) subdural Hematoma.</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<u>Had artificial pace-maker for strokes - Adams attacks</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input checked="" type="checkbox"/> Notify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>at home (Baltimore)</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>12/16/71 at night</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>fell in his bath room</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> 19 <u>71</u> to <u>12/28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>12/28/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>H. LEVEQUE</u>		23D. ADDRESS <u>Swain Hospital of Baltimore</u>		DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-3-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. National Mem. Ch.</u>	
24D. LOCATION <u>Laurel</u>		24E. (City, town, or county) <u>MD.</u>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>	
ADDRESS <u>1727 M.</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-656 71 12185				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12185	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>WERNER, MARY Christina</b>				2. DATE AND HOUR OF DEATH <b>12-27-1971 8:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>903</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>				C. CITY OR TOWN <b>BALTO MD.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>636 E. 36TH STREET BALTO MD 21218</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>04-30-88</b>	9. AGE (in years) lost birthday <b>83</b>	If Under 1 Yr. Months: <b>83</b> Days: <b>7</b> Hours: <b>27</b> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William SCHAWAB</b>				14. MOTHER'S MAIDEN NAME <b>ROSIANA W. GLENZER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>220-46-4849</b>		17. INFORMANT <b>Mrs Charles Birx Hagerstown, Md.</b>	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Pneumonia</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Renal Failure</b> (B) <b>HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIO SCLEROTIC CARDIO V. Disease</b> (C) <b>Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indefinitely medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-25</b> 19 <b>71</b> to <b>12-27</b> 19 <b>71</b> that (I) (we) lost saw the deceased alive on <b>12-27</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Carlos A. Battilana MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-27-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Carlos A. Battilana MD</b>				23D. ADDRESS <b>Union Memorial Hospital MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/30/1971</b>		24C. NAME of CEMETERY or CREMATORY <b>Oaklawn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Charles A. Schwab</b>		25C. FUNERAL DIRECTOR <b>G. Trima</b> ADDRESS <b>3512 Frederick Ave.</b>			



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E-152 71 12186

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 71 12186

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

EVANS OGDEN A.

2. DATE AND HOUR OF DEATH

12/27/71

5:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)BALTIMORE CITY HOSP.  
4940 Eastern Avenue

BALTIMORE, Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

M.D.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

340 S. Macom St.

21224

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12/24/1900

9. AGE (In years  
last birthday)

71

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Bread Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Bakery

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Johnson Evans

14. MOTHER'S MAIDEN NAME

Mary Whitney

15. Was Deceased Ever in U. S. Armed Forces?

(If yes, give war or dates of service)

Yes

WW 2

6. SOCIAL  
SECURITY NO.

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH: Records Baltimore, Maryland 21224

18.

571.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

SEPTICEMIA

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

71 hrs

(B)

DUE TO, OR AS A CONSEQUENCE OF:

DECUBITUS ULCER

2 mo.

(C)

CIRRHOSIS

15 yrs.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

chronic alcoholism

15 yrs.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-9 1971 to 12-27 1971  
that (I) (we) last saw the deceased alive on 12-27 1971 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Smar Sines M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12/27/71

23C. PHYSICIAN'S  
NAME (Type)

SURAT SINASA

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Avenue Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/30/71

24C. NAME of CEMETERY or CREMATORY

American Legion Cemetery

24D. LOCATION

(City, town, or county)

Crisfield, Somerset, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 5 1972

25B. NAME OF REGISTRAR

J. E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Bradshaw &amp; Sons, Crisfield, Md. 21817

ADDRESS

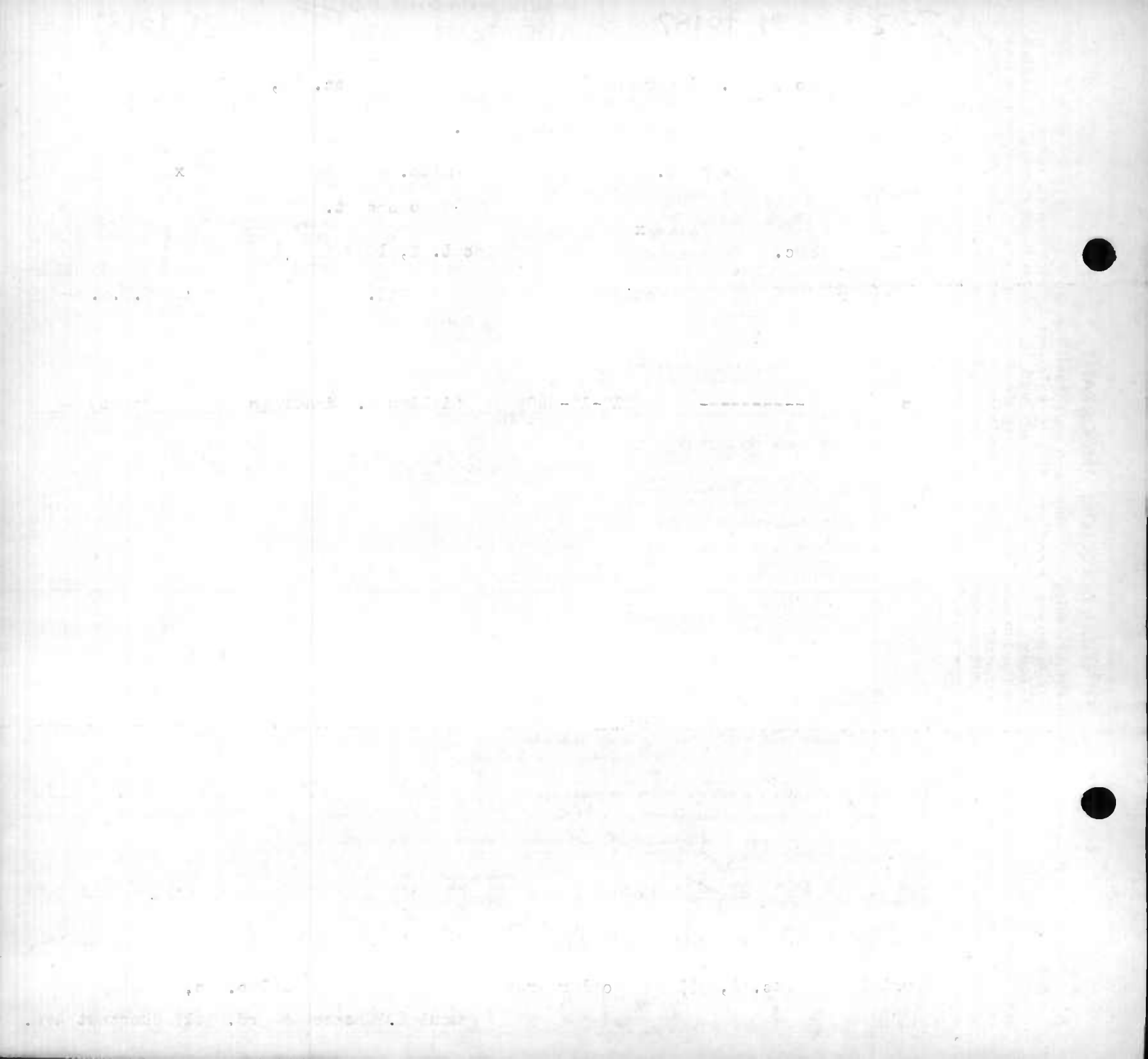




# FUNERAL DIRECTOR: IMPORTANT

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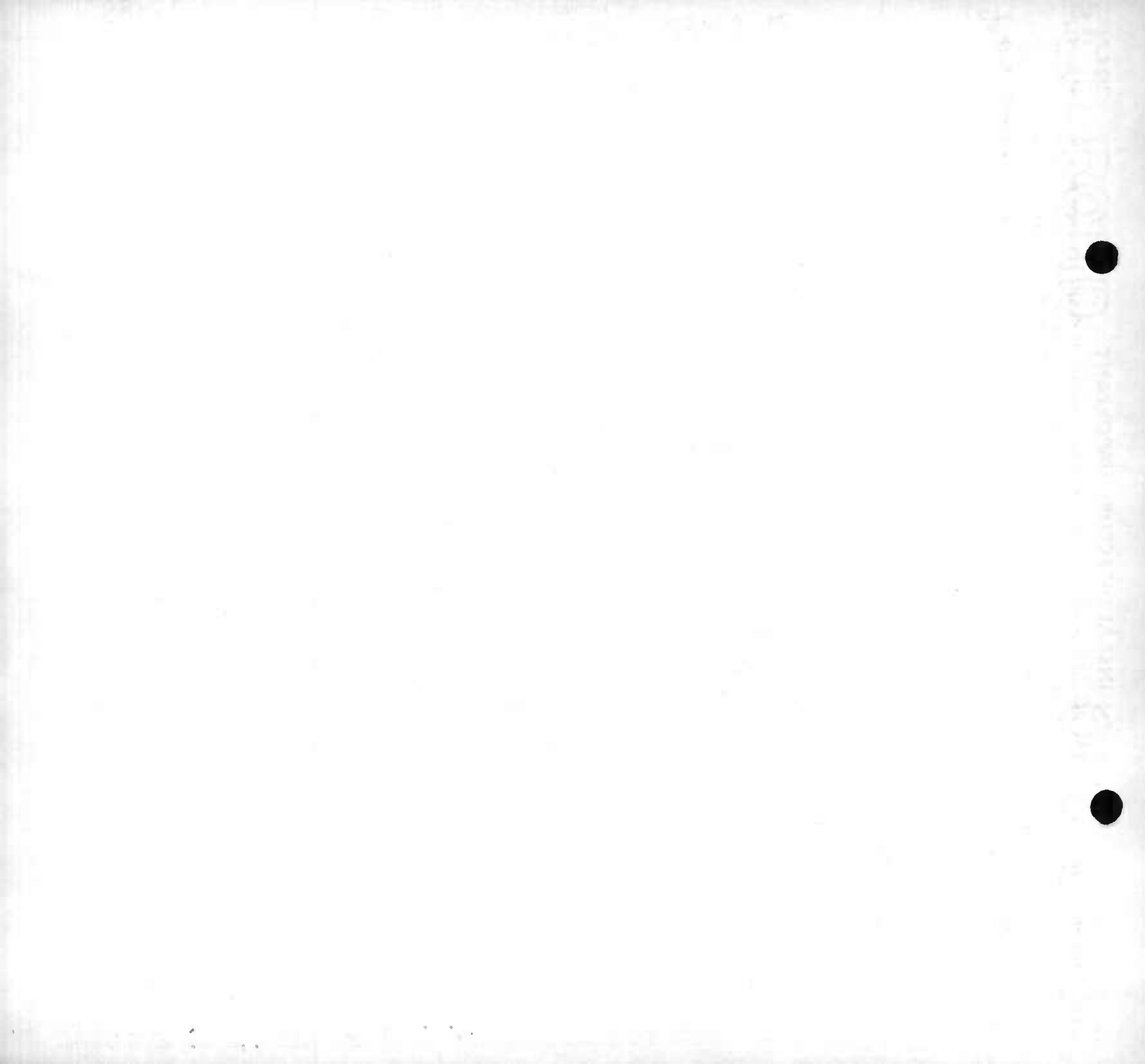
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12187</b>	
<b>2-565</b> <b>71 12187</b>		<b>CERTIFICATE OF DEATH</b>			
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print)		<b>2. DATE AND HOUR OF DEATH</b>			
<b>Joseph A. Zimmerman</b>		<b>Dec. 29, 1971</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>		<b>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</b> A. STATE      B. COUNTY			
<b>830 Powers St.</b>		<b>Md.</b>			
<b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		<b>C. CITY OR TOWN</b>		<b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>00</b>		<b>Balto.</b>		<b>1306</b>	
<b>5. SEX</b> Male		<b>6. RACE</b> Cauc.		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> Sept. 2, 1899		<b>9. AGE (In years last birthday)</b> 72		<b>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> Farmer	
<b>11. BIRTHPLACE (State or foreign country)</b> Md.		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.		<b>13. FATHER'S NAME</b> ?	
<b>14. MOTHER'S MAIDEN NAME</b> ?		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) no		<b>16. SOCIAL SECURITY NO.</b> 217-18-5605	
<b>17. INFORMANT</b> Lillian E. Zimmerman		<b>ADDRESS</b> (same)			
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					
<b>arteriosclerotic C.V.R. Dis</b>					
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b> 0		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from Jan 19 70 to Dec 29 19 71, that (I) (we) lost saw the deceased alive on Dec 24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>Edward L. Glassman</i>				<b>23B. DATE SIGNED</b> 12/31/71	
<b>23C. PHYSICIAN'S NAME (Type)</b> EDWARD L. GLASSMAN M.D.				<b>23D. ADDRESS</b> 4037 Belts Rd.	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> Burial		<b>24B. DATE</b> Dec. 31, 1971		<b>24C. NAME OF CEMETERY OR CREMATORY</b> Poplar Grove	
<b>24D. LOCATION</b> Balto. Co.		<b>25A. DATE REC'D BY HEALTH DEPT.</b> JAN 3 1972			
<b>25B. NAME OF REGISTRAR</b> Robert E. Jarboe, Jr.		<b>25C. FUNERAL DIRECTOR</b> Paul E. Chenoweth 3rd. 3617 Chestnut Ave.			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 12188</u>	
BIRTH NO. <u>R-426</u>		71 12188			
1. NAME OF DECEASED (Type or Print) <u>RELLER CLARA D.</u>			2. DATE AND HOUR OF DEATH <u>Dec. 30 1971 6:30 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION Memorial Hospital.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD.</u> CITY <u>Baltimore</u>	
				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1522 TUNLAW Rd. 21218</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-13-80</u>	9. AGE (in years last birthday) <u>91</u>	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Emil Dippel</u>		14. MOTHER'S MAIDEN NAME <u>LOUISA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. JACK DeHoff</u> ADDRESS <u>(SAME)</u>	
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY Embolus</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Thrombophlebitis</u> <u>ASC VD</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASC VD</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-11-71</u> 19 to <u>12-30-71</u> 19 that (I) (we) last saw the deceased alive on <u>12-30-71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>12-30-71</u>		23C. PHYSICIAN'S NAME (Type) <u>JAIRO PAMIREZ MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/3/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount</u>	
24D. LOCATION <u>Baltimore</u>		24E. STATE <u>Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>	
25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>		25D. ADDRESS <u>4905 York Rd. Balto., Md. 21212</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

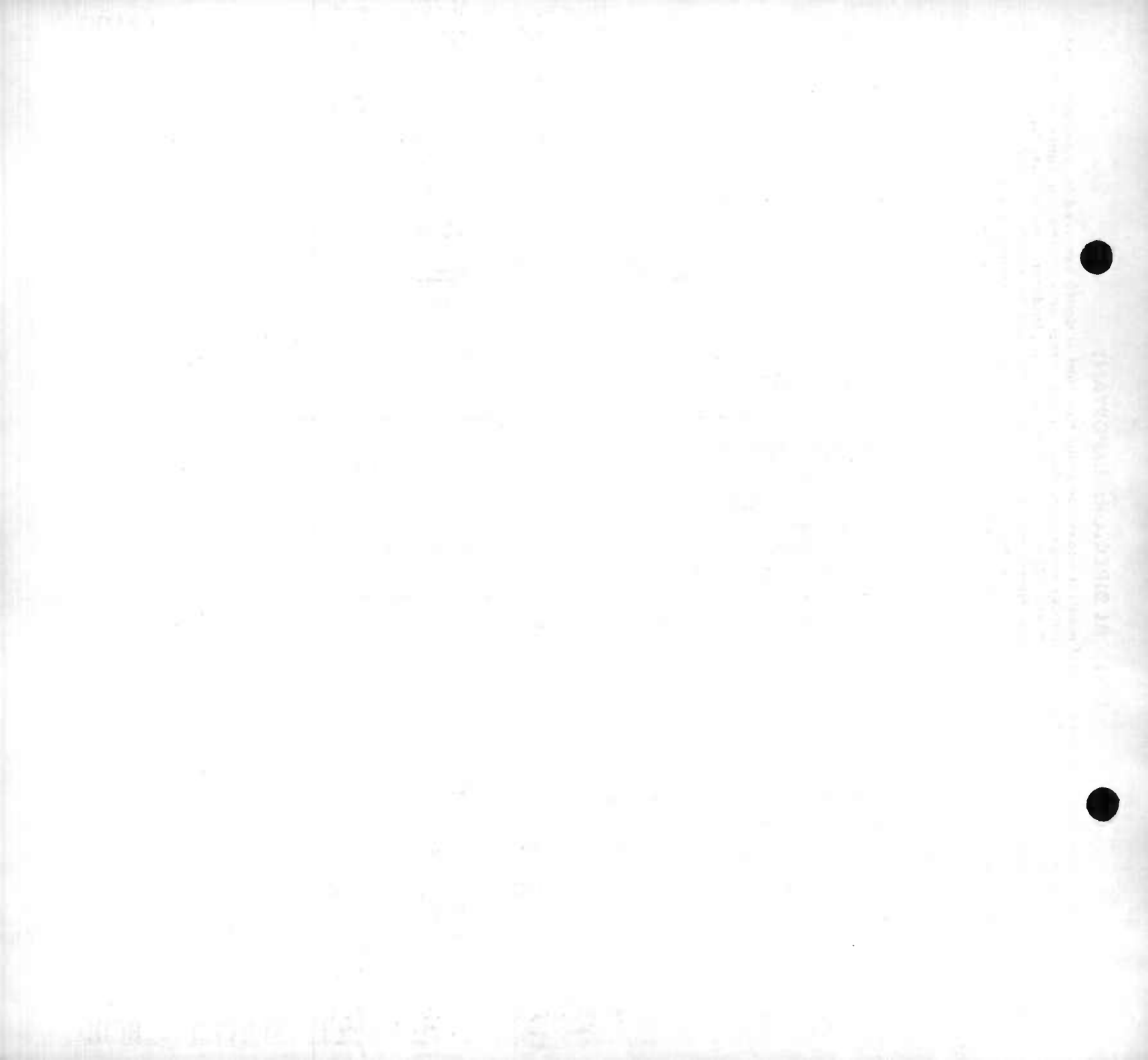
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">71 12189</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">N-242 71 12189</span> <span style="font-size: 1.2em;">BIRTH NO.</span> </div>					
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.1em;">Robert J. Nicholson</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.1em;">12-31-71 5 am M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.1em;">91 Keswick</span> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.1em;">Md.</span> B. COUNTY <span style="font-size: 1.1em;">2755</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.1em;">MT. Washington</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.1em;">1812 SOUTH ROAD</span>		
<b>5. SEX</b> <span style="font-size: 1.1em;">M</span>	<b>6. RACE</b> <span style="font-size: 1.1em;">W</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.1em;">4-29-1876</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.1em;">95</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">PROPRIETOR -</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.1em;">TYPEWRITER BUSINESS SELF-EMPLOYED</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.1em;">Kent County md</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.1em;">Robert H. Nicholson</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.1em;">Laura Lusby</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">NO</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.1em;">218-30-5040</span>	<b>17. INFORMANT</b> <span style="font-size: 1.1em;">Keswick Records</span> <b>ADDRESS</b>		
<b>18. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.1em;">arteriosclerotic cardiovascular disease</span> (B) <span style="font-size: 1.1em;">Ren. Arteriosclerosis</span> DUE TO, OR AS A CONSEQUENCE OF: (C)		
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.1em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.1em;">No</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Involuntarily medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that</b> (1) (this hospital) attended the deceased from <span style="font-size: 1.1em;">Dec 19 1969</span> to <span style="font-size: 1.1em;">31 Dec 1971</span> that (1) (we) last saw the deceased alive on <span style="font-size: 1.1em;">31 Dec 1971</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
<b>23A. SIGNATURE</b> <span style="font-size: 1.1em;">Harold P. Biehl MD</span>			<b>23B. DATE SIGNED</b> <span style="font-size: 1.1em;">12/31/71</span>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.1em;">DR. HAROLD P. BIEHL</span>			<b>23D. ADDRESS</b> <span style="font-size: 1.1em;">KESWICK HOME</span>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.1em;">Burial</span>	<b>24B. DATE</b> <span style="font-size: 1.1em;">1/3/72</span>	<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.1em;">Chester Cemetery</span>		<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.1em;">Chestertown Md.</span>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.1em;">JAN 3 1972</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.1em;">H. W. Jenkins</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.1em;">H. W. Jenkins &amp; Sons Co.</span> <b>ADDRESS</b> <span style="font-size: 1.1em;">4905 York Rd. Balto., Md. 21212</span>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12190</u>	
BIRTH NO. <u>71 12190</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>KENNEY NORMAN D.</u>			2. DATE AND HOUR OF DEATH <u>Dec. 24. 1971 8:25 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>CITY OF Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1026 WOODSON Rd. 2768</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>05-10-04</u>	9. AGE (In years last birthday) <u>67</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Philadelphia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
10B. KIND OF BUSINESS OR INDUSTRY			14. MOTHER'S MAIDEN NAME <u>Jennie DURLING</u>		
13. FATHER'S NAME <u>JOHN H. Kenney</u>			17. INFORMANT <u>JENNIFER DORRIS</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		ADDRESS
18. <u>205.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>CHRONIC myelocytic Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF:		
			(B) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>ASCVD + Peripheral Vascular Disease</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-02-71</u> 19____ to <u>12-24-71</u> 19____ that (I) (we) last saw the deceased alive on <u>12-24-71</u> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>12-24-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JAIRO RAMIREZ</u>				23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12/28/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ANATOLY BOARD OF MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		25B. NAME OF FUNERAL HOME <u>[Signature]</u>		25C. ADDRESS <u>MORTUARY SERVICE - BCHD</u>	

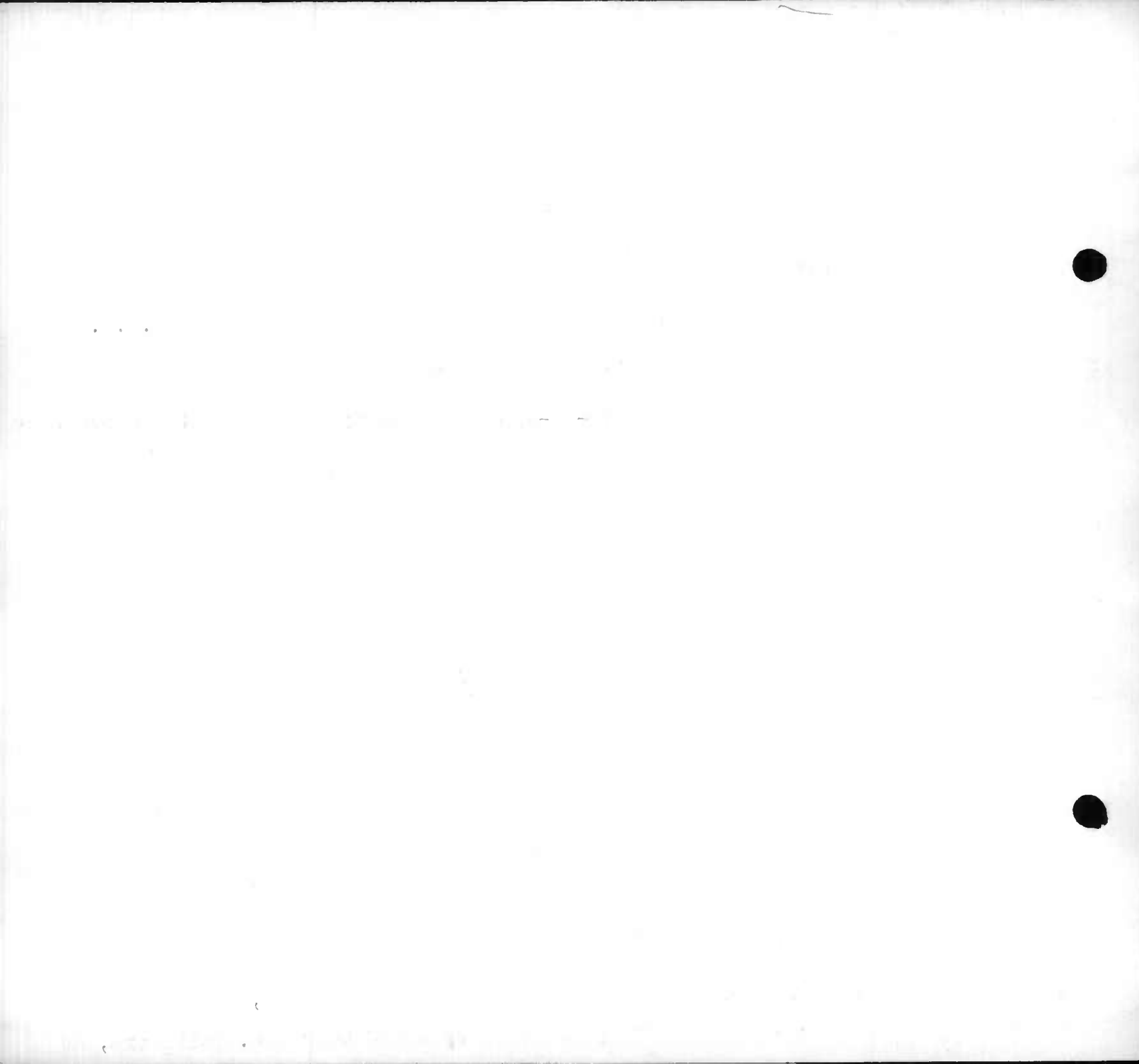




# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
13-400		71 12191		71 12191	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
BELL GEORGE N				8.05 PM 12/31/71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
Lutheran Hospital of Maryland				Maryland BALTO 5300	
5. SEX				6. DATE OF BIRTH	
Male				9-7-95	
7. RACE				7. AGE (In years last birthday)	
White				76	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				If Under 1 Yr. Months Days	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
Retired Warehouse Man				Maryland	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY	
?				U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME	
No				Anne ?	
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS	
218-05-3502				Mr George W Bell 5031 Truesdale Av	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Pulmonary Decompensation	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(Ventilatory failure)	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Ch. Pulmonary (obstructive) emphysema	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION				(C) DUE TO, OR AS A CONSEQUENCE OF:	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-30-1971 to 12-31-1971 that (I) (we) last saw the deceased alive on 12-31-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
C. M. Memon M.D.				12-31-71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ABDUL MAJID MEMON M.D.				730 Ashburton Street Baltimore Md 21216	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1/4/72		X Loudon Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 4 1972		D. C. G. 300 300		Leopard J Buck Inc. Baltimore, Md	



# FUNERAL DIRECTOR: IMPORTANT

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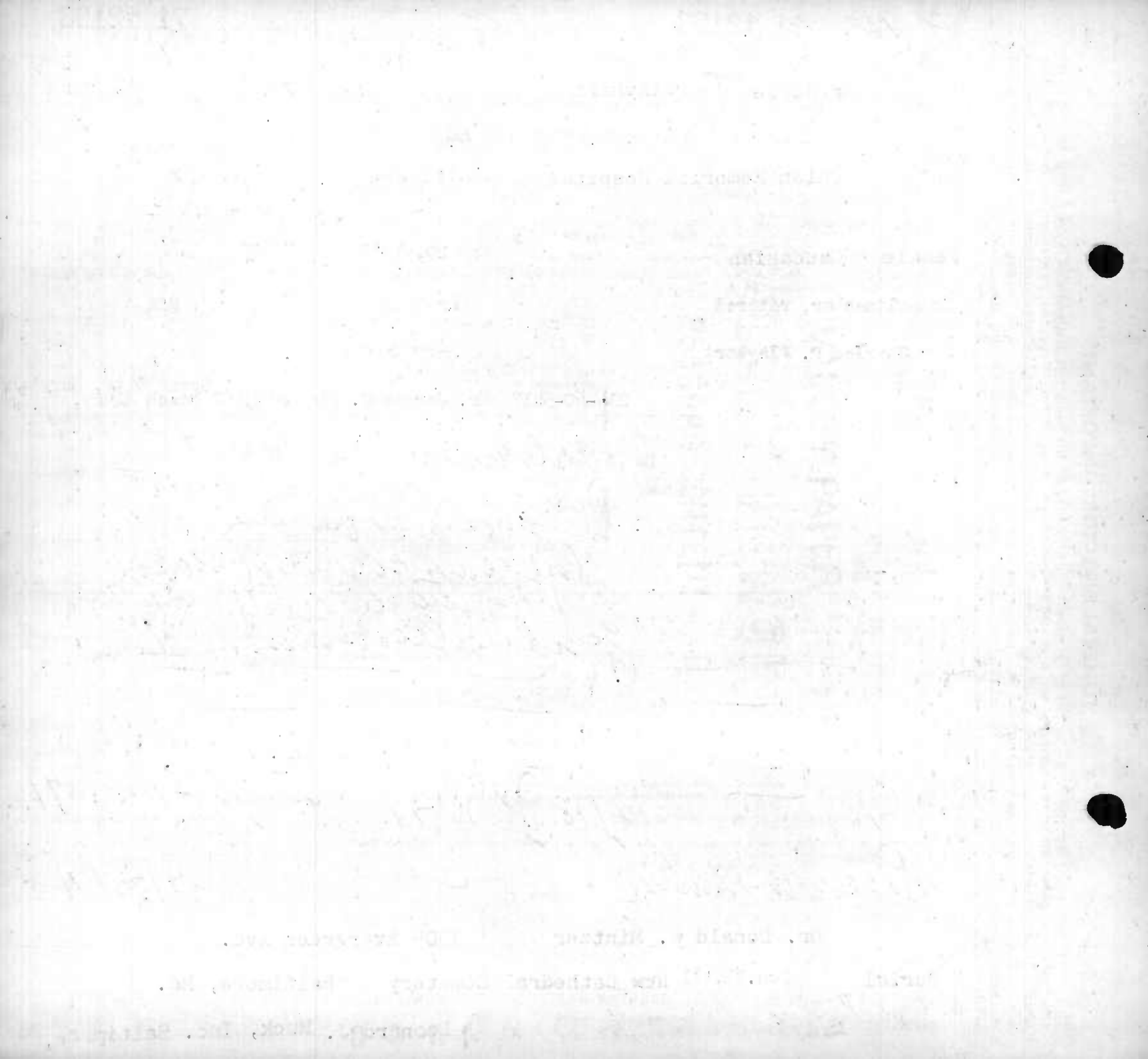
H-536 71 12192				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12192	
1. NAME OF DECEASED (Type or Print) <b>ELMYRA P. HENDRIX</b>				2. DATE AND HOUR OF DEATH <b>Dec. 30, 1971</b> <span style="float: right;">10<sup>15</sup> M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 LONG GREEN NURSING HOME</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2747</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2900 Westfield Ave.</b>			
5. SEX <b>female</b>	6. RACE <b>caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-6-1890</b>	9. AGE (in years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Mins.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>John Patterson</b>			
14. MOTHER'S MAIDEN NAME <b>Ella Vaughn</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>217-01-1680</b>				17. INFORMANT ADDRESS <b>Alberta Coleman, 2900 Westfield Ave.</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>I</b> I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Atherosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 70</b> to <b>Dec 30 71</b> that (I) (we) last saw the deceased alive on <b>Dec 29 71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dr. William G. Helfrich</b>				23B. DATE SIGNED <b>12-31-71</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. William G. Helfrich</b>	
23D. ADDRESS <b>5006 Roland Ave, Baltimore, Md.</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1-3-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Bethel Presbyterian Cem..</b>		24D. LOCATION (City, town, or county) (State) <b>Madonna, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Richard E. ...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Buck, Inc. - Balto, Md. - 11</b>			

619-17-59

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>7-463 71 12193</b></p> <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>71 12193</b></p>	
<p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED (Type or Print) <b>Marjorie T. Flayhart</b></p>		<p>2. DATE AND HOUR OF DEATH <b>12/28/71 12:45P M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Memorial Hospital</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>907</b></p> <p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>1740 GORRUCH AVE</b></p>	
<p>5. SEX <b>Female</b></p>	<p>6. RACE <b>Caucasian</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>May 20, 1906</b></p>
<p>9. AGE (In years lost birthday) <b>65</b></p>		<p>If Under 1 Yr. Months: Days: Hours: Min.</p>	<p>If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Schoolteacher, retired</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>13. FATHER'S NAME <b>Charles R. Flayhart</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Mary Magann</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b></p>		<p>16. SOCIAL SECURITY NO. <b>214-40-5417</b></p>	
<p>17. INFORMANT <b>Mr. Jerome C. Flayhart</b></p>		<p>ADDRESS <b>Ocean City, Maryland 902 Beach Hiway,</b></p>	
<p>18. <b>412.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Heart Disease - Enlarged Heart - Congestive Failure</b></p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic Heart Disease - Enlarged Heart - Congestive Failure</b></p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension CVD - left ventricle</b></p> <p>(C) <b>Hypertrophy left ventricle</b></p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <b>0</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>12/18/71</b> to <b>12/27/71</b> and that (I) <del>(we)</del> last saw the deceased alive on <b>12/18/71</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Dr. Donald W. Mintzer</b></p>		<p>23B. DATE SIGNED <b>12/30/71</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>Dr. Donald W. Mintzer</b></p>		<p>23D. ADDRESS <b>3009 Evergreen Ave.</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>Dec. 31, '71</b></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Leonard J. Ruck, Inc.</b></p>	
<p>25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b></p>		<p>ADDRESS <b>Baltimore, Md.</b></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-320				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12194	
BIRTH NO. 71 12194		1. NAME OF DECEASED (Type or Print) <b>LUDWIG, FRANK J. Jr.</b>				2. DATE AND HOUR OF DEATH <b>12-30-1971 10.15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <b>MARYLAND</b>		B. COUNTY <b>BALTO</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
<div style="position: absolute; top: 0; left: 0; font-weight: bold; font-size: 1.2em;">                     CERTIFICATE AMENDED - 1/4/72                      Union Memorial Hospital                 </div>						D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>RT. #1 BOX 251, WHITE HALL MD 21156</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>01-31-09</b>		9. AGE (In years last birthday) <b>62</b>		10. If Under 1 Yr. Months Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gas Co.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HELPER.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>FRANK J. LUDWIG SR.</b>				14. MOTHER'S MAIDEN NAME <b>EMILY KOEBER</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes Navy 1943-</b>				16. SOCIAL SECURITY NO. <b>215-01-0433</b>		17. INFORMANT <b>Mrs. Grace C. Ludwig</b>		ADDRESS (Same)	
18. <b>410.9 I</b> 1945				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIAC ARREST</b>					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(B) <b>Myocardial Infarction.</b>					
ANTECEDENT CAUSES				(C) <b>Arteriosclerotic Cardiovascular Dis.</b>					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from <b>12-28</b> 19 <b>71</b> to <b>12-30</b> 19 <b>71</b> that (I) (we) lost saw the deceased alive on <b>12-30</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Carlos A. Bottilana MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-30-71</b>			
23C. PHYSICIAN'S NAME (Type) <b>Carlos A. Bottilana MD</b>				23D. ADDRESS <b>Union Memorial Hospital MD.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/71.</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Guck</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Guck, Inc. Balto. Md. 21214</b>		ADDRESS			

1/13/72 - Letter from Union Memorial Hospital dated 1/7/1972. Signed by M's.

Theresa M. Winter, RRA, Director, Medical Records.

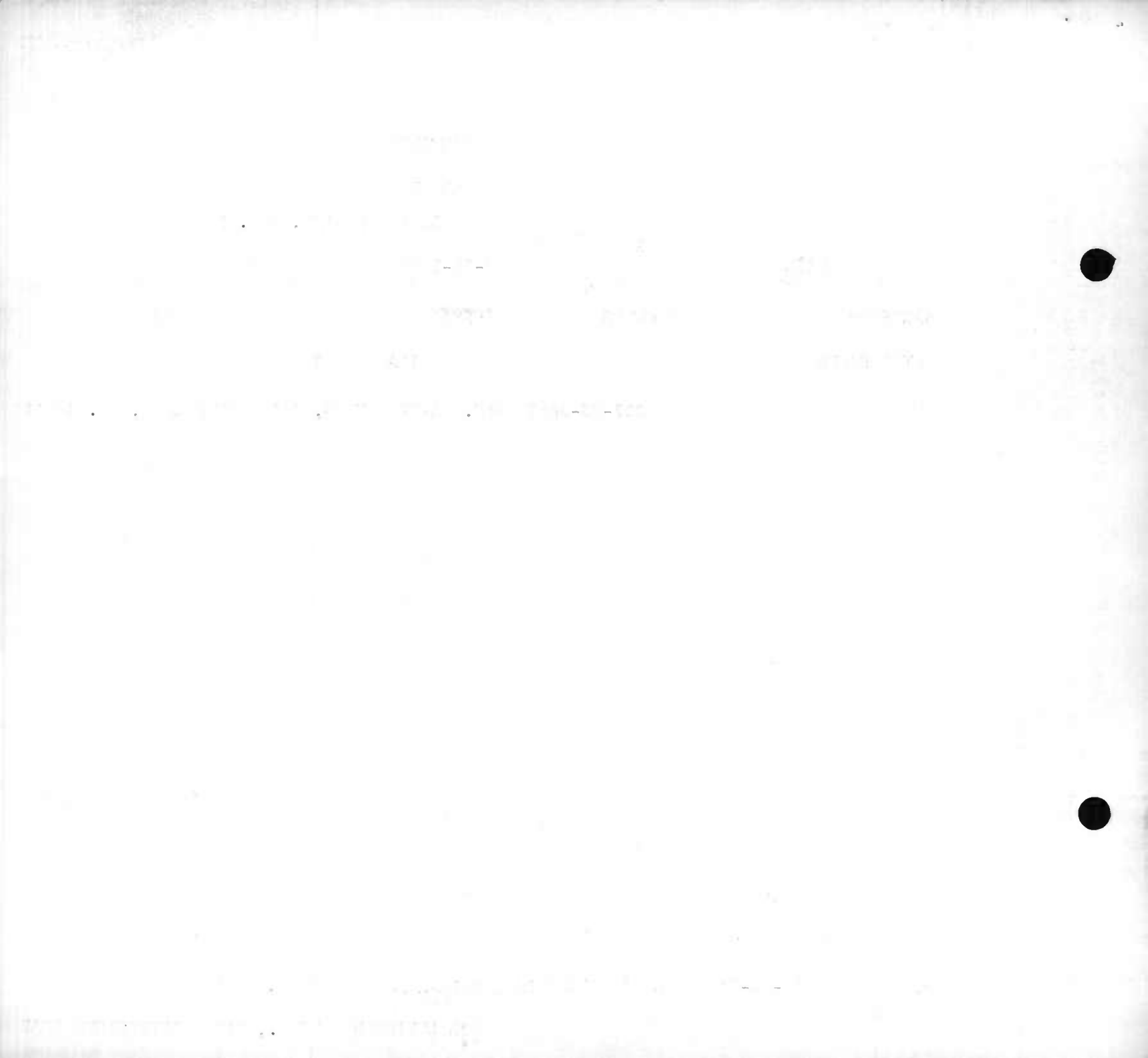
*APC*



# FUNERAL DIRECTOR: IMPORTANT

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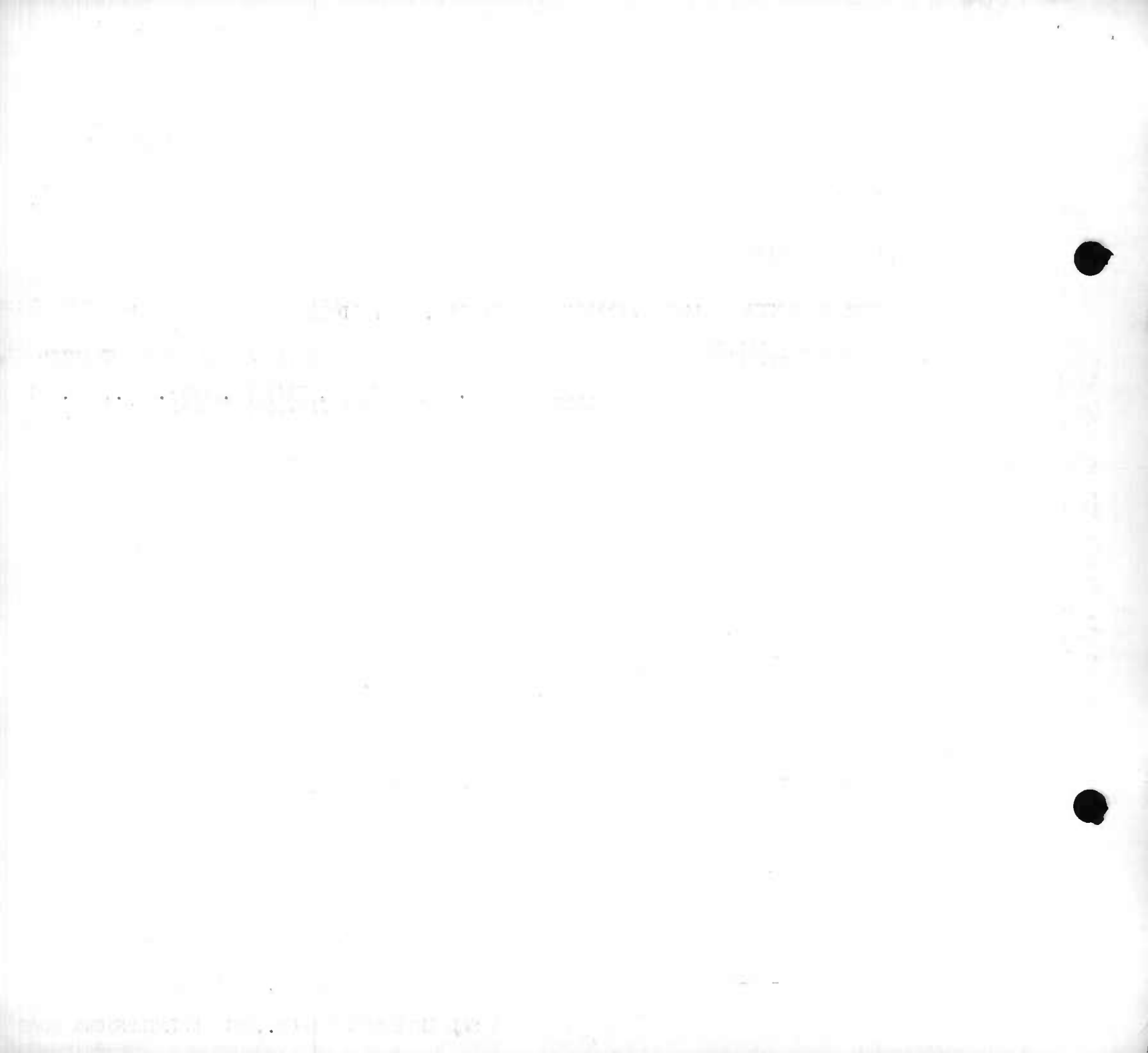
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
S-220		71 12195		71 12195	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
BENJAMIN SYKES		12/29/71		10:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		A. STATE MARYLAND		B. COUNTY 2720	
42		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4012 FORDS LANE, APT. 1A			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1889	9. AGE (In years last birthday) 82	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY CLOTHES		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME MEYER SACHS		14. MOTHER'S MAIDEN NAME IDA ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-03-9697		17. INFORMANT MRS. HATTIE SYKES, 4012 FORDS LANE, APT. 1A #15	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 410.941.250.9		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Atherosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: myocardial infarction Feb. 1970 (C) Nephrotic Nephritis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden 10 years 10 1/2 yrs. 10 1/2 yrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1955 to 12/29/71 that (I) (we) last saw the deceased alive on 12/20/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A.A. Silver		23B. DATE SIGNED 12/29/71			
23C. PHYSICIAN'S NAME (Type) A.A. SILVER M.D.		23D. ADDRESS 6210 PARK HTS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-31-71		24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL (MISHKON ISRAEL SECTION)	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE RECEIVED BY HEALTH DEPT. URGENT		25B. NAME OF REGISTRAR 971000	
25C. FUNERAL DIRECTOR SQL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>522-400</u> <u>71 12196</u>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>CYRIL W. KEENE</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>DEC. 29, 1971</u> <u>6:45 A.M.</u>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL</u> <u>42</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <u>CITY</u> B. COUNTY <u>STATE</u> <u>BALTIMORE, MARYLAND</u> <u>2730</u> <b>C. CITY OR TOWN</b> <u>BALTIMORE</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>7111 PARK HEIGHTS AVE. #15</u>		
<b>5. SEX</b> <u>MALE</u>	<b>6. RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4-18-88</u>	<b>9. AGE</b> (In years last birthday) <u>83</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>XXXXXX BROKER</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>LOAN XXXXXXXX</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>LONDON, ENGLAND XXX</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S.</u>		<b>13. FATHER'S NAME</b> <u>WILLIAM CHARLES KEENE</u>		
<b>14. MOTHER'S MAIDEN NAME</b> <u>XXXXXX ROSINA MIRIAM TRAVISH</u>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
<b>16. SOCIAL SECURITY NO.</b> <u>XXXX</u>		<b>17. INFORMANT</b> <u>MRS. ELLEN KEENE, 7111 PK. HIGHTS AVE., APT. 811</u> <u>XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX</u>		
<b>18. CAUSE OF DEATH</b>				
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>157.01</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. (A) <u>CARDIO-PULMONARY ARREST</u> (B) <u>PULMONARY EDEMA, CHF</u> (C) <u>CARCINOMA OF HEAD OF PANCREAS</u> (D) <u>METASTASIS</u> <u>MT of poss. pneumonia</u>				
<b>II</b>				
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <b>19A. DATE OF OPERATION</b> <u>11/30/71</u>				
<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>Weight loss &amp; vomiting</u>				
<b>20A. AUTOPSY?</b> (Yes or No) <input type="checkbox"/> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>				
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
<b>21F. HOW DID INJURY OCCUR?</b>				
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>NOV. 15</u> <b>19</b> <u>71</u> <b>to</b> <u>DEC. 29</u> <b>19</b> <u>71</u> <b>that (I) (we) last saw the deceased alive on</b> <u>DEC. 29</u> <b>19</b> <u>71</u> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>CAYETANO T. PIZON, M.D.</u> <b>23C. PHYSICIAN'S NAME (Type)</b>				<b>23B. DATE SIGNED</b> <u>DEC. 29, 1971</u>
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>24B. DATE</b> <u>12-31-71</u>		
<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>OHED SHALOM</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b>		<b>25B. NAME OF REGISTRAR</b> <u>71000</u>		
<b>25C. FUNERAL DIRECTOR</b> <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>		<b>ADDRESS</b>		



S-632

71 12197

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12197

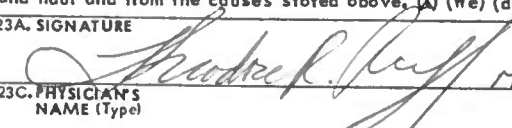
BIRTH NO.

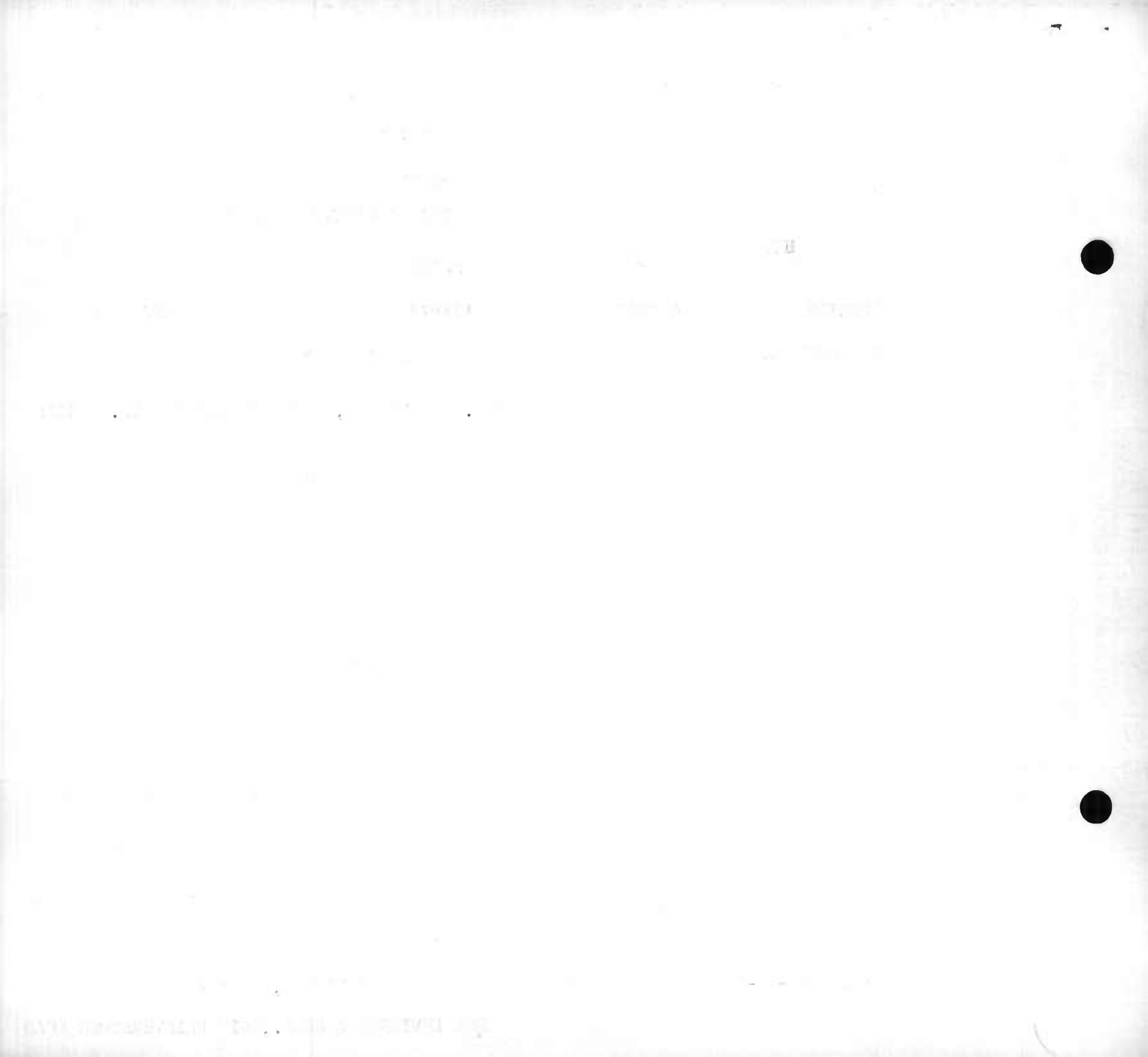
1. NAME OF DECEASED (Type or Print) JULIUS SCHWARTZ		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOSPITAL OR INSTITUTION DRUID HILL PARK 3101 Swan Drive		3. DATE PRONOUNCED DEAD Month Day Year December 29, 1971 Hour 11:00 A. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <del>XXX</del> MARYLAND B. COUNTY <del>BALTO</del> BALTO		6. SEX Male 7. RACE White 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH JAN. 18, 1907 10. AGE (In years last birthday) 64 11. BIRTHPLACE (State or foreign country) NEW YORK, NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA 13. FATHER'S NAME WILLIAM SCHWARTZ	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <del>TRAFFIC CHECKER</del> TRAFFIC DEPT. OF TRAFFIC & TRANSIT		15. MOTHER'S MAIDEN NAME IDA KEISLER	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 185-07-1186	
18. INFORMANT ADDRESS MRS. MINNIE SCHWARTZ, 6821 WESTRIDGE RD. #21207		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Gunshot wounds of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unk.	
22C. WHERE DID INJURY OCCUR? Unk.		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Missing 12/20/71	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Found shot in park	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/29/71			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-30-71	
24C. NAME OF CEMETERY or CREMATORY EOBROISKER BENEFICIAL CIRCLE		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS	

1-10-72XX

1-10-72 - Letter from - Office of the Chief Medical Examiner, Ronald N. Kornblum, M.D.  
Assistant Medical Examiner

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>71 12198</b>	
BIRTH NO. <b>S-542 71 12198</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>SARAH SAMUELSON</b>		2. DATE AND HOUR OF DEATH <b>December 27, 1971 11:20 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>91 LEVINDALE</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2740</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3108 PARKINGTON AVENUE</b>	
5. SEX <b>Female</b>	6. RACE <b>WHITE</b> <b>Human</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	8. DATE OF BIRTH <b>XXXXX</b>
9. AGE (in years last birthday) <b>99</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>LATVIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ISAAC HOFFMAN</b>		14. MOTHER'S MAIDEN NAME <b>LENA ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. ANN FISHER, 3108 PARKINGTON AVE. #21215</b>		ADDRESS	
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Recurrent Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>XXXXX</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b> (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? <b>INJURY OCCUR?</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 6</b> 19 <b>65</b> to <b>December 27</b> 19 <b>71</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>December 27</b> 19 <b>71</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED <b>December 28, 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>Theodore R. Reiff, M.D.</b>		23D. ADDRESS <b>Levindale</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-29-71</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>SHAAREI TFILOH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Robert C. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON</b>		ADDRESS <b>&amp; BROS., 6010 REISTERSTOWN ROAD</b>	

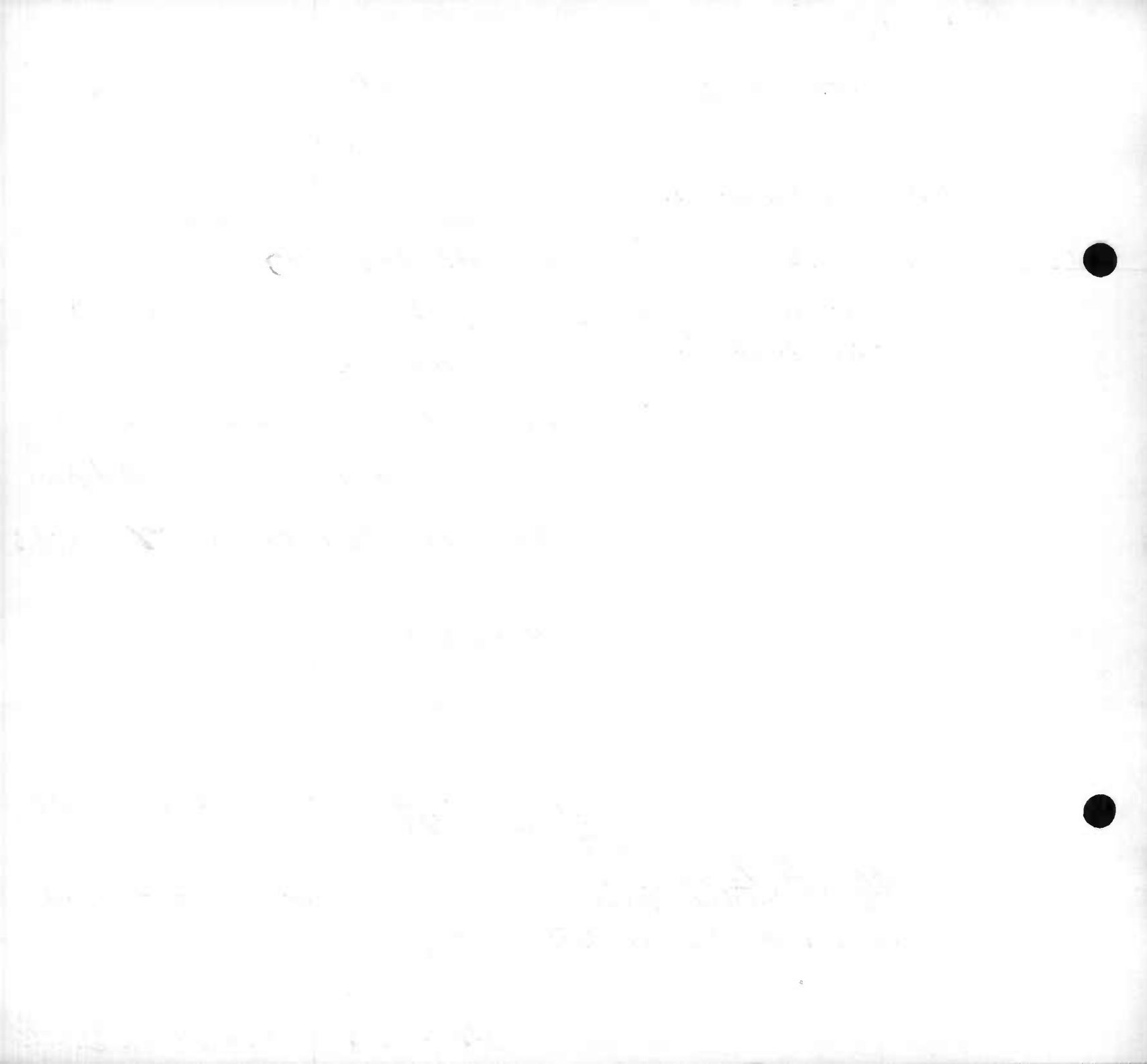




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>M-460 71 12199</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>REG. NO. 71 12199</span> </div>			
1. NAME OF DECEASED (Type or Print) <u>John H. Miller</u>		2. DATE AND HOUR OF DEATH <u>12/30/71</u> <u>11:15</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Univ of Maryland</u>		A. STATE <u>Md</u> B. COUNTY <u>Baltimore</u>	
		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3113 Kenyon Ave</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/99</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BUYING CAN MFG. CO.</u>	9. AGE (In years last birthday) <u>72</u>
13. FATHER'S NAME <u>John A. Miller</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY NO. <u>215-05-5984</u>		14. MOTHER'S MAIDEN NAME <u>Minnie C. Miller</u>	
17. INFORMANT <u>Louis H. Miller, 312 Bar Harbor B.</u>		ADDRESS <u>2122</u>	
18. <u>207.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Stem-cell leukemia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>2 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>ASCVD</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/23</u> 19 <u>71</u> to <u>12/30</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/30</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Alan G. Stahl, M.D.</u>		23B. DATE SIGNED <u>12/30/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Alan G. Stahl, M.D.</u>		23D. ADDRESS <u>Univ. Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Bur</u>		24B. DATE <u>JAN 7 1972</u>	
24C. NAME OF CEMETERY or CREMATORY <u>LORRAINE MARBOLEON</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. CO., MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1972</u>		25B. NAME OF REGISTRAR <u>John E. J. J. J.</u>	
25C. FUNERAL DIRECTOR <u>CHURCH FUNERAL HOME</u>		ADDRESS <u>BALTO. MD. 21206</u>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

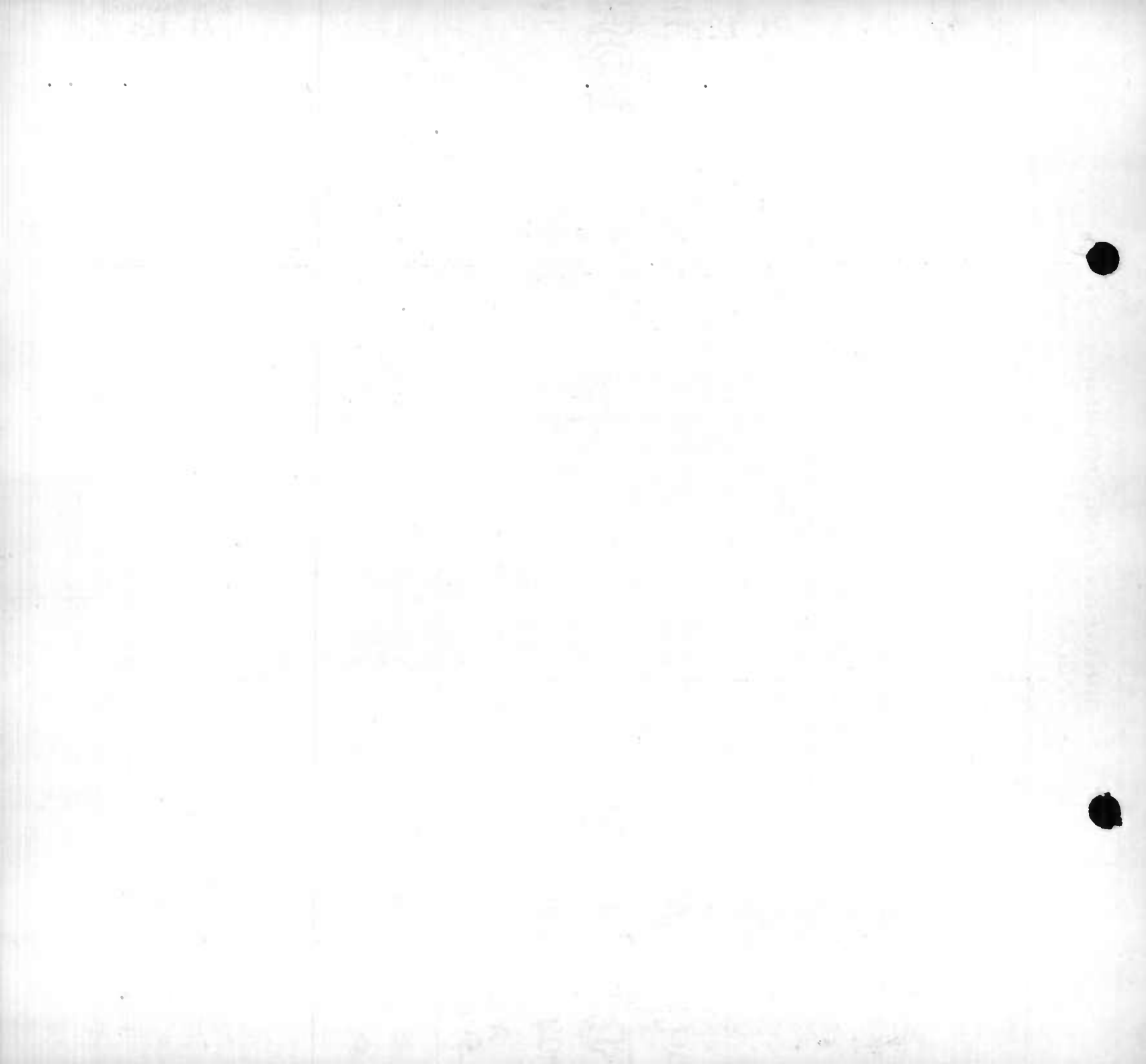
B-400 71 12200		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12200	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) THOMAS J. BOYLE		2. DATE AND HOUR OF DEATH December 29 71 18:40 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. CITY OR TOWN DUNDALK			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 1913 HOLBORNE ROAD	
5. SEX Male	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/01	9. AGE (In years last birthday) 70	10. If Under 1 Yr. Months: Days: Hours: Min.	11. If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker		10B. KIND OF BUSINESS OR INDUSTRY STEEL		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS WM. D. BOYLE		14. MOTHER'S MAIDEN NAME MARY ADAMS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-09-9080		17. INFORMANT BCH RECORDS: 4940 Eastern Avenue Baltimore, Maryland 21224		ADDRESS	
18. 43691 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH CARDIORESPIRATORY ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular Accident (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). HYPERTENSIVE CARDIOVASCULAR DISEASE							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (If yes, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>XX</del> (this hospital) attended the deceased from Dec 27 19 71 to December 29 19 71 that <del>NO</del> (we) last saw the deceased alive on December 29 19 71 and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>XX</del> (We) (did) <del>XXXX</del> view the body after death.							
23A. SIGNATURE Chu-shin Chiu MD		23B. DATE SIGNED 12-29-71		23C. PHYSICIAN'S NAME (Type) CHU-SHIN CHIU, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3 JAN 72		24C. NAME of CEMETERY or CREMATORY JACKED HEART CEM.		24D. LOCATION BALTO. CO., MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR J. M. O. O. O.		25C. FUNERAL DIRECTOR ULRICH FEDERAL HOME, DUNDALK, MD 21222		ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12201</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>T-260</b></span> <span><b>71 12201</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print) <i>William E. Tucker Sr.</i>			2. DATE AND HOUR OF DEATH <i>Dec 30, 1971 12.30 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>2534</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 327 Washburn Ave</i>			C. CITY OR TOWN <i>Balto</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>327 Washburn Ave 21225</i>		
5. SEX <i>M</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 21, 1898</i>	9. AGE (In years last birthday) <i>73</i>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Bar Tender</i>	11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Isaac Tucker</i>			14. MOTHER'S MAIDEN NAME <i>Cora Collins</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>212 10 5695</i>	17. INFORMANT ADDRESS <i>Katherine Tucker 327 Washburn Ave 21225</i>		
<div style="display: flex;"> <div style="flex: 1;"> <p>18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.</p> </div> <div style="flex: 1;"> <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i></p> <p>(B) <i>Arrhythmia and</i> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <i>Cerebral Vascular Disease</i></p> </div> <div style="flex: 1;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that (I) (<del>this hospital</del>) attended the deceased from <i>Jan 1964</i> 19 <i>64</i> to <i>Dec 30</i> 19 <i>71</i>, that (I) (<del>we</del>) last saw the deceased alive on <i>December 24</i> 19 <i>71</i> and that in (my) (<del>our</del>) opinion death occurred on the date and hour and from the causes stated above. (I) (<del>We</del>) (<del>did not</del>) view the body after death.</p>					
23A. SIGNATURE <i>Mario J. Reda MD</i>				23B. DATE SIGNED <i>12/30/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>MARIO J. REDA MD.</i>				23D. ADDRESS <i>4016 RITCHIE HWY BALTO, MD 21205</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/3/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Ritchie Hwy Balto Md. 21225</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 4 1972</i>		25B. NAME OF REGISTRAR <i>Robert A. [unclear]</i>		25C. FUNERAL DIRECTOR ADDRESS <i>McGully Funeral Home 237 Patapsco Ave 21225</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 12202	
T-400 71 12202					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ADOLPH ( ADOLPHUS ) H. THIELE		December 30, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
40 St. Agnes Hospital				Maryland Baltimore	
5. SEX		6. RACE		C. CITY OR TOWN	
Male		White		Baltimore	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER	
Retired Inspector		State of Maryland		167 Stafford Street	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		21227	
Henry W. Thiele		Kathe ( Unknown )			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes		W W I 217-20-1823		Mrs. Margaret M. Thiele, 167 Stafford St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Acute Myocardial Infarction			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
II		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) HYPERTENSION			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 07 to 12/30 19 71 that (I) (we) last saw the deceased alive on 12/28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
James N. Frederick				12/31/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				1311 Francis Avenue, Baltimore, Md. 21227	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1-3-1972		Lake View Memorial Park	
25A. DATE REC'D. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 4 1972		Howard H. Hubbard		4107 Wilkens Ave. 21229	

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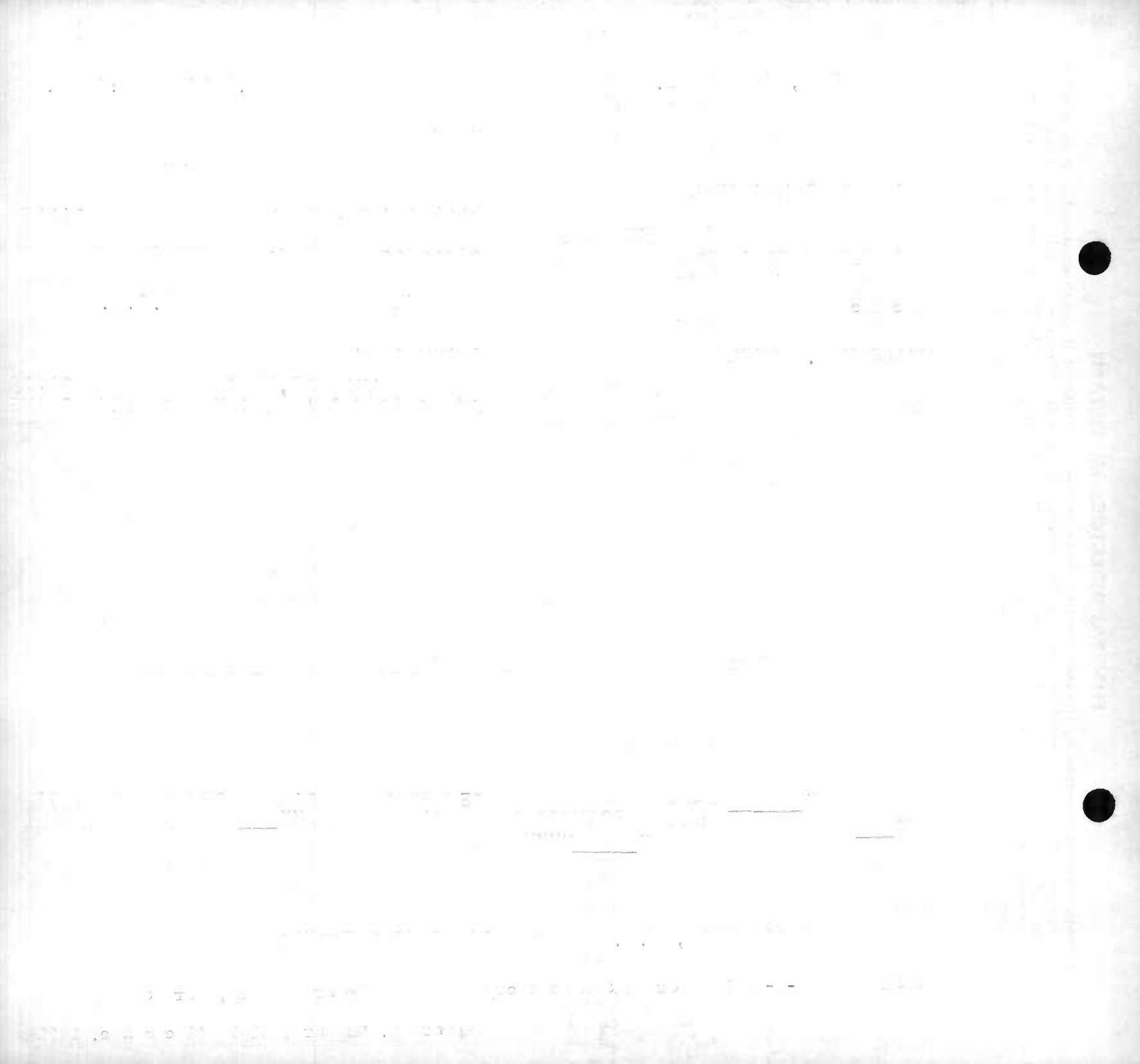


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 71 12203

BIRTH NO. W-320 71 12203		1. NAME OF DECEASED (Type or Print) WATTS, SALOME A.		2. DATE AND HOUR OF DEATH DECEMBER 28, 1971 9:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. CITY OR TOWN	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL		A. STATE MARYLAND		B. COUNTY 2541	
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 08/12/10		9. AGE (in years last birthday) 61		10. UNDER 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HERBERT A. WHEELER		14. MOTHER'S MAIDEN NAME EDITH GRAY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT BALTIMORE, MARYLAND ADDRESS 21229 ST AGNES HOSPITAL CATON & WILKENS AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Pericarditis in chronic Pulm. edema</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertrophy of heart &amp; hypertension</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Concomitant by popliteal kidneys</i> (C) <i>Old brain infarction right occlusion right renal artery</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 6 yrs	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) <input checked="" type="checkbox"/> this hospital attended the deceased from DECEMBER 28 19 71 to DECEMBER 28 19 71 that (1) <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 28 19 71 and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes noted above. (1) <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jose Apter</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) JOSE APTER, M.D.	
23D. ADDRESS ST AGNES HOSPITAL		23E. FUNERAL DIRECTOR		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-3-1972		24C. NAME of CEMETERY or CREMATORY Crestlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Howard County, Maryland		24E. DATE REC'D BY HEALTH DEPT. JAN 4 1972		24F. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. DATE	
Howard H. Hubbard, 4107 Wilkens Ave, 21229					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 12204	
BIRTH NO. M-320 71 12204		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MATTOX, FRANK			2. DATE AND HOUR OF DEATH 12/29/71 6:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 903		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL 33			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 601 E 34TH ST.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-16	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Sears Robuck Co.		11. BIRTHPLACE (State or foreign country) Wolcott, Ind.	
12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME MATTOX, PERMAN			14. MOTHER'S MAIDEN NAME KEAN, EMMA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No - - -		16. SOCIAL SECURITY NO. 305-18-9772		17. INFORMANT ADDRESS Manjorie L Mattox 601 E. 34th St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 396.01 Attempted Mitral + Aortic Valve Replacement CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VALVE Replacement 8 HRS (B) Rheumatic Valvular Heart Disease 37 yrs DUE TO, OR AS A CONSEQUENCE OF: Disease (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). MEDICAL CERTIFICATION 19A. DATE OF OPERATION 1/2/72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Rheumatic Heart Disease 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 12/27 19 71 to 12/29 19 71 that (I) (we) lost saw the deceased alive on 12/25 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE James R. Reynolds MD DEGREE 23B. DATE SIGNED 12/29/71 23C. PHYSICIAN'S NAME (Type) JAMES R. REYNOLDS 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1/4/72 24C. NAME OF CEMETERY or CREMATORY MeadowLake Presbyterian 24D. LOCATION (City, town, or county) (State) Wolcott, Indiana 25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS Donovan Funeral Home 3818 Roland Ave					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

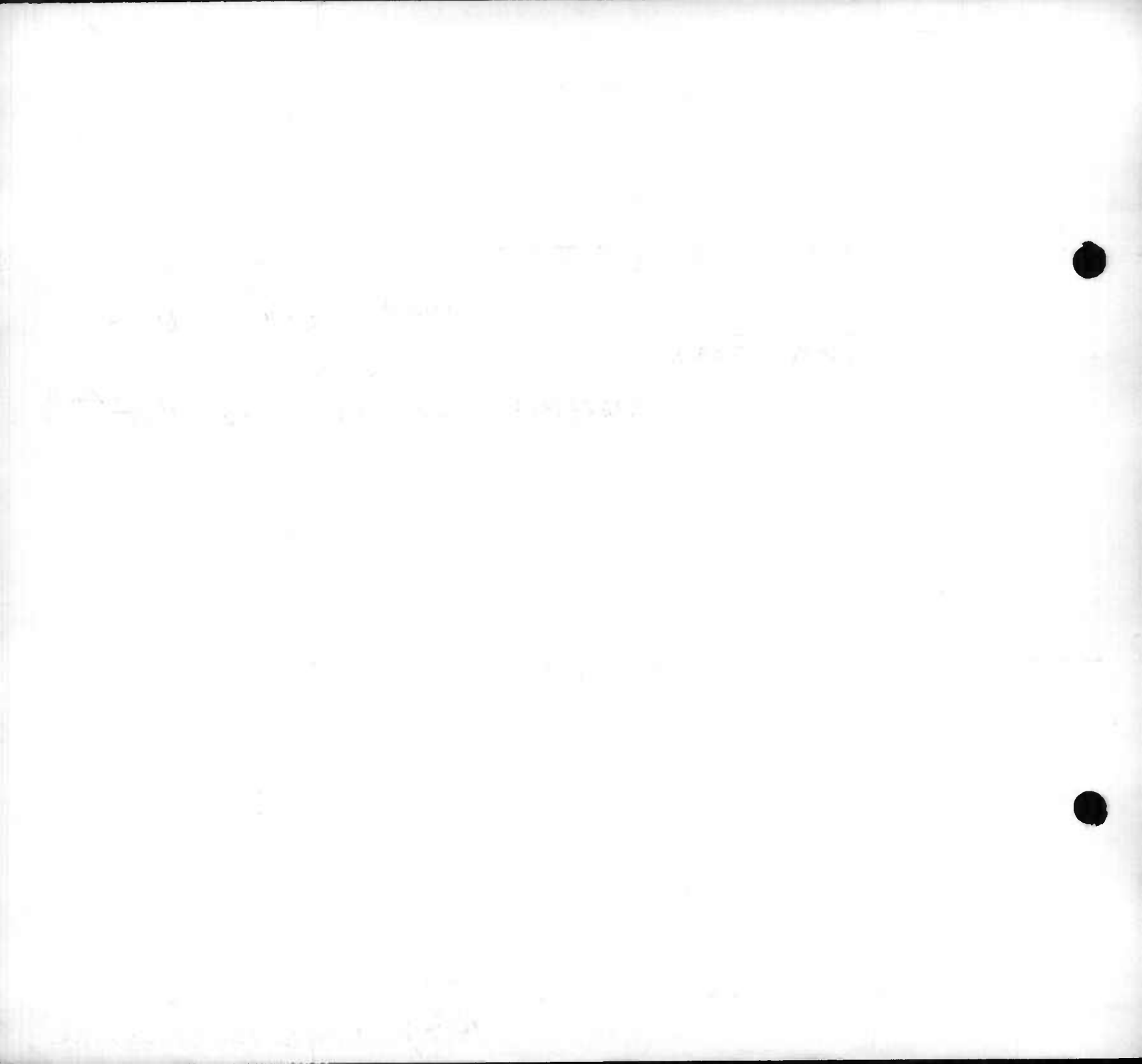
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <b>71 12205</b>	
<b>K-560 71 12205</b> BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>KNORR MARIE A</b>			
2. DATE AND HOUR OF DEATH <b>Dec. 25 1971 6:30 PM</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>44 UNION MEMORIAL HOSPITAL</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>CITY OF BALTIMORE</b>				5. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. STREET AND NUMBER <b>7248 CONLEY ST. BALTO 5300</b>				7. SEX <b>F</b> 8. RACE <b>W</b> 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>FREDERICK F. LINDBOURT</b>			
14. MOTHER'S MAIDEN NAME <b>KOTRA, Mary</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>215-64-8115</b>				17. INFORMANT <b>Norman Knorr (husband) 7248 Conley St.</b> ADDRESS			
18. <b>571.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>HEPATIC COMA</b> ANTECEDENT CAUSES <b>Post-Necrotic cirrhosis</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <b>NO</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11-05-71</b> 19 to <b>12-25-71</b> 19 that (I) (we) last saw the deceased alive on <b>12-25-71</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b> DEGREE				23B. DATE SIGNED <b>12-25-71</b>			
23C. PHYSICIAN'S NAME (Type) <b>JAIRO RAUTER</b> DEGREE				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/29/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Bohemian National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Homes, Inc.</b> ADDRESS <b>3331 Brehms Lane, Balto Md 21213</b>		25D.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>71 12206</b>	
<b>A-352 71 12206</b>		<b>CERTIFICATE OF DEATH</b>	
BIRTH NO. <b>71 12206</b>		1. NAME OF DECEASED (Type or Print) <b>MARY J. ADAMS</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <b>12/31/71 2:00 A.M.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> <b>602</b>	
5. SEX <b>F</b> 6. RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		E. STREET AND NUMBER <b>2538 E. FAYETTE ST.</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		8. DATE OF BIRTH <b>06/06/07</b> 9. AGE (In years last birthday) <b>64</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JIMK SEARS</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>236242822</b>	
17. INFORMANT <b>Mrs Henry Heine</b>		ADDRESS <b>Belts 37</b>	
18. <b>12/19/71</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<b>UREMIA</b>	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		<b>MIXED MESODERMAL TUMOR</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
<b>—</b>		(C) <b>—</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>—</b>	
19A. DATE OF OPERATION <b>—</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/27</b> 19 <b>71</b> to <b>12/31</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12/31</b> 19 <b>71</b> and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>H. Spooner</b>		23B. DATE SIGNED <b>12/31 2:20 AM</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. SPOONER</b>		23D. ADDRESS <b>1034 WOODJON RD. APT 2 BALT. MARYLAND</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/13/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Philip C. Crash</b>		ADDRESS <b>1211 Chesapeake Ave</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-261 71 12207		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12207	
1. NAME OF DECEASED (Type or Print) <b>RUTH MARGARET DeGRAFFT</b>		2. DATE AND HOUR OF DEATH <b>12/30/71 7:45 M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>BON SECOURS Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>HOWARD</b>			
5. SEX <b>Female</b> 6. RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/03/06</b>	
9. AGE (in years last birthday) <b>65</b>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13. FATHER'S NAME <b>George Coppersmith Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Slagle</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>213-01-1220</b>		17. INFORMANT <b>Wm. E. DeGrafft</b> ADDRESS <b>10109 Carillon Dr. Ellicott City, Md.</b>	
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>metastatic ca of the breast, right</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>1969</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca of breast</b>		20A. AUTOPSY? (Yes or No) <b>N/A</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>N/A</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>N/A</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>N/A</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>N/A</b>		21F. HOW DID INJURY OCCUR? <b>N/A</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>11/26</b> 19 <b>71</b> to <b>12/30</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12-30</b> 19 <b>71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Gerardo M. Lopez</b>		23B. DATE SIGNED <b>12-30-71</b>		23C. PHYSICIAN'S NAME (Type) <b>GERARDO M. LOPEZ</b>	
23D. ADDRESS <b>BON SECOURS Hospital</b>		24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>Jan 3, 1972</b> 24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b> 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Stirling Funeral Estate</b> ADDRESS <b>736 Edmondson Ave. Catonsville, Md 21228</b>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-520 71 12208

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 71 12208

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

SADIE C. BANKS

2. DATE AND HOUR OF DEATH

12/25/71

8:30 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived at the time of death or residence before admission)

A. STATE

B. COUNTY

MARYLAND

RT 2, BOX 183, ARNOLD, MD. 21012

C. CITY OR TOWN

ANNAPOLIS,

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

RT#2 BOX 183

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

10/17/98

9. AGE (in years last birthday)

73

10. Under 1 Yr. 11. Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

GRIFFIN, ELI

14. MOTHER'S MAIDEN NAME

JOSEPHINE GRIFFIN, (HOLLAND)

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

219 16 1210

17. INFORMANT

Thomas Griffith

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of death, e.g. heart failure, asphyxia, etc. It means the disease or condition which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS giving rise to the above (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF:

(B)

METASTATIC CARCINOMA

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? If yes or No

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/21 1971 to 12/25 1971

that (I) (we) last saw the deceased alive on 12/25 1971 and that (in my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Robert C. Bast

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

12/25/71

23C. PHYSICIAN'S NAME (Type)

Dr. Robert Bast M.D.

23D. ADDRESS

JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

25A. DATE REC'D BY HEALTH DEPT.

JAN 4 1972

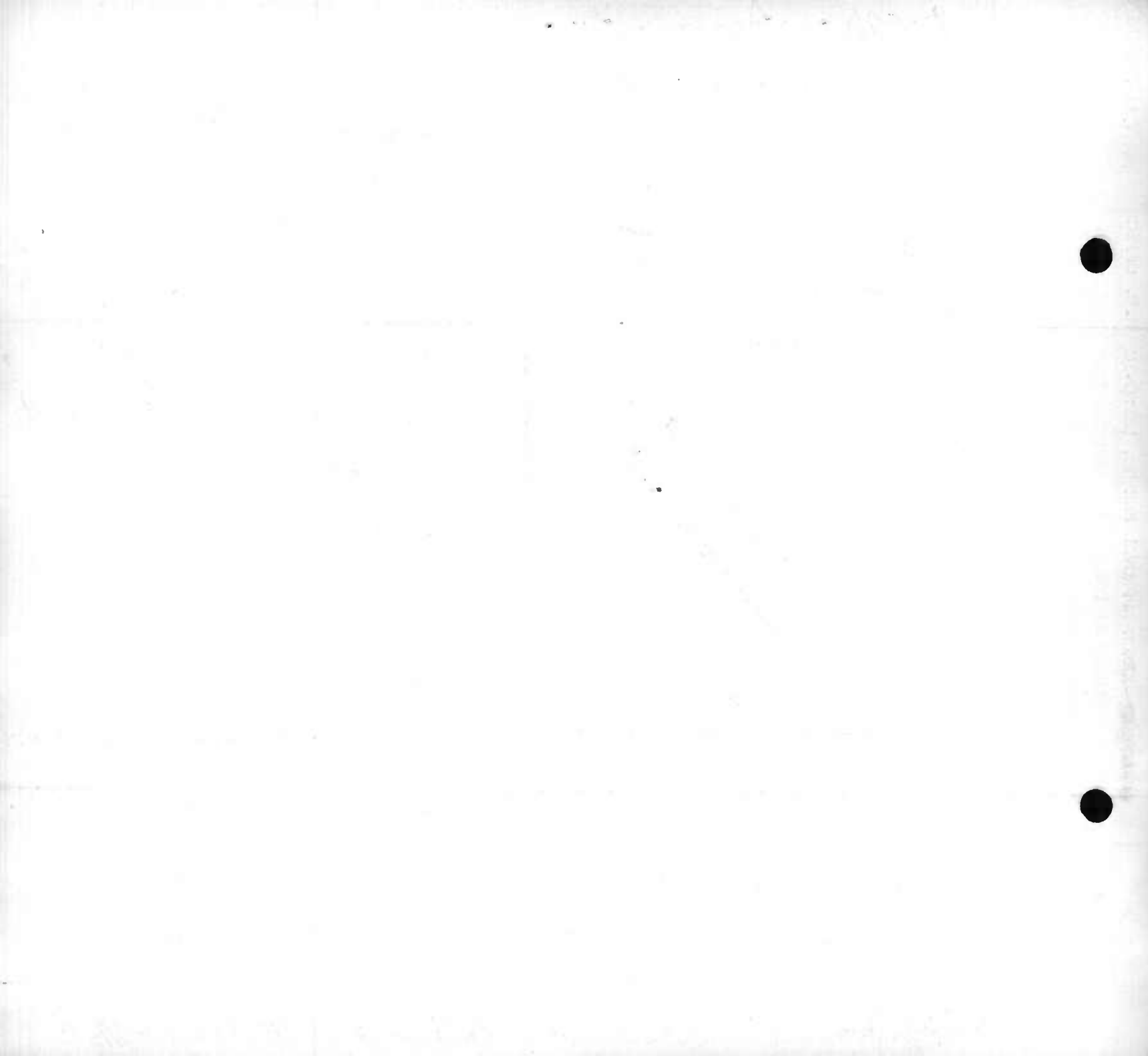
25B. NAME OF REGISTRAR

Robert E. Nalley, M.D.

25C. FUNERAL DIRECTOR

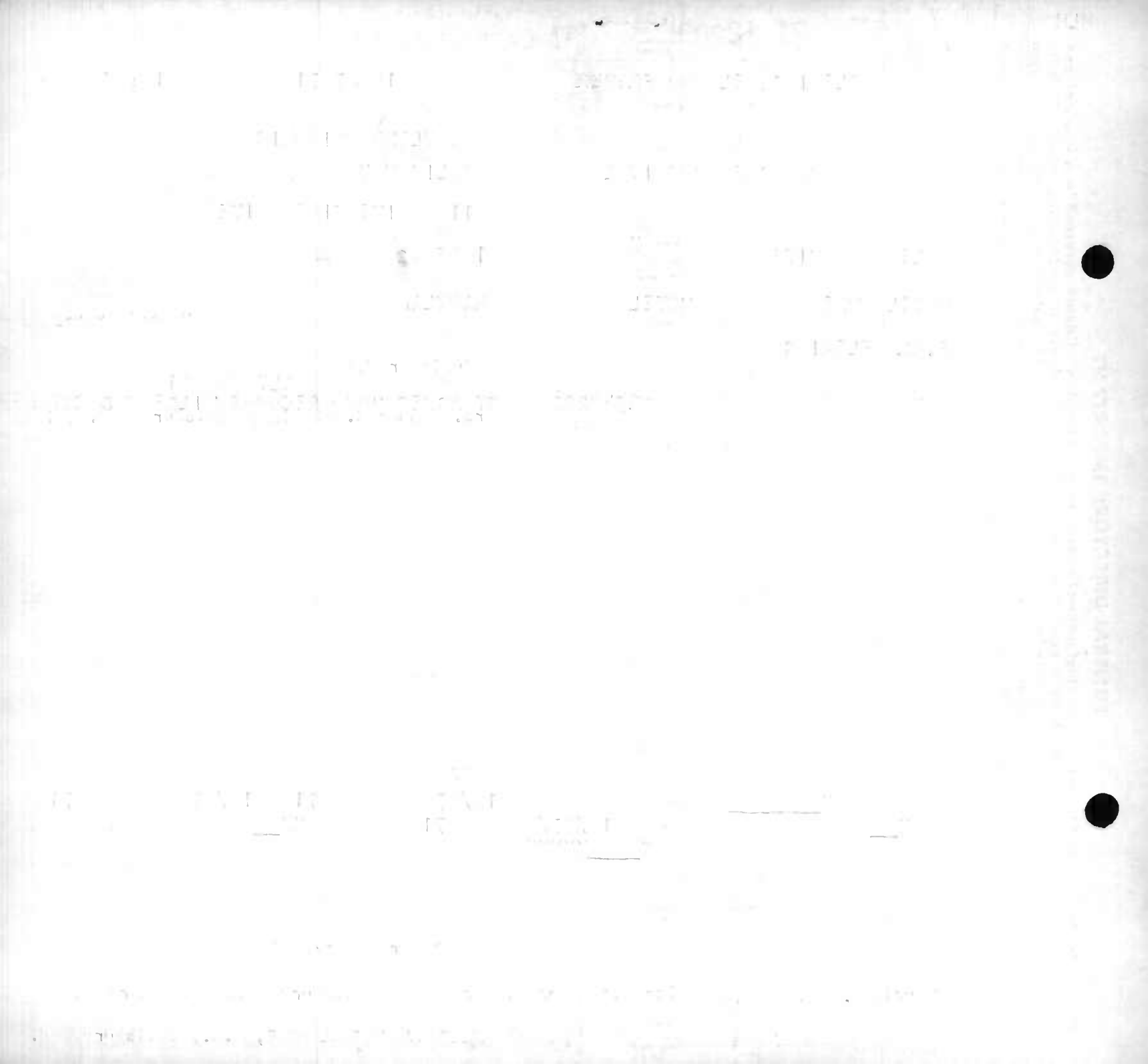
William Reese, Anna M.D.

ADDRESS



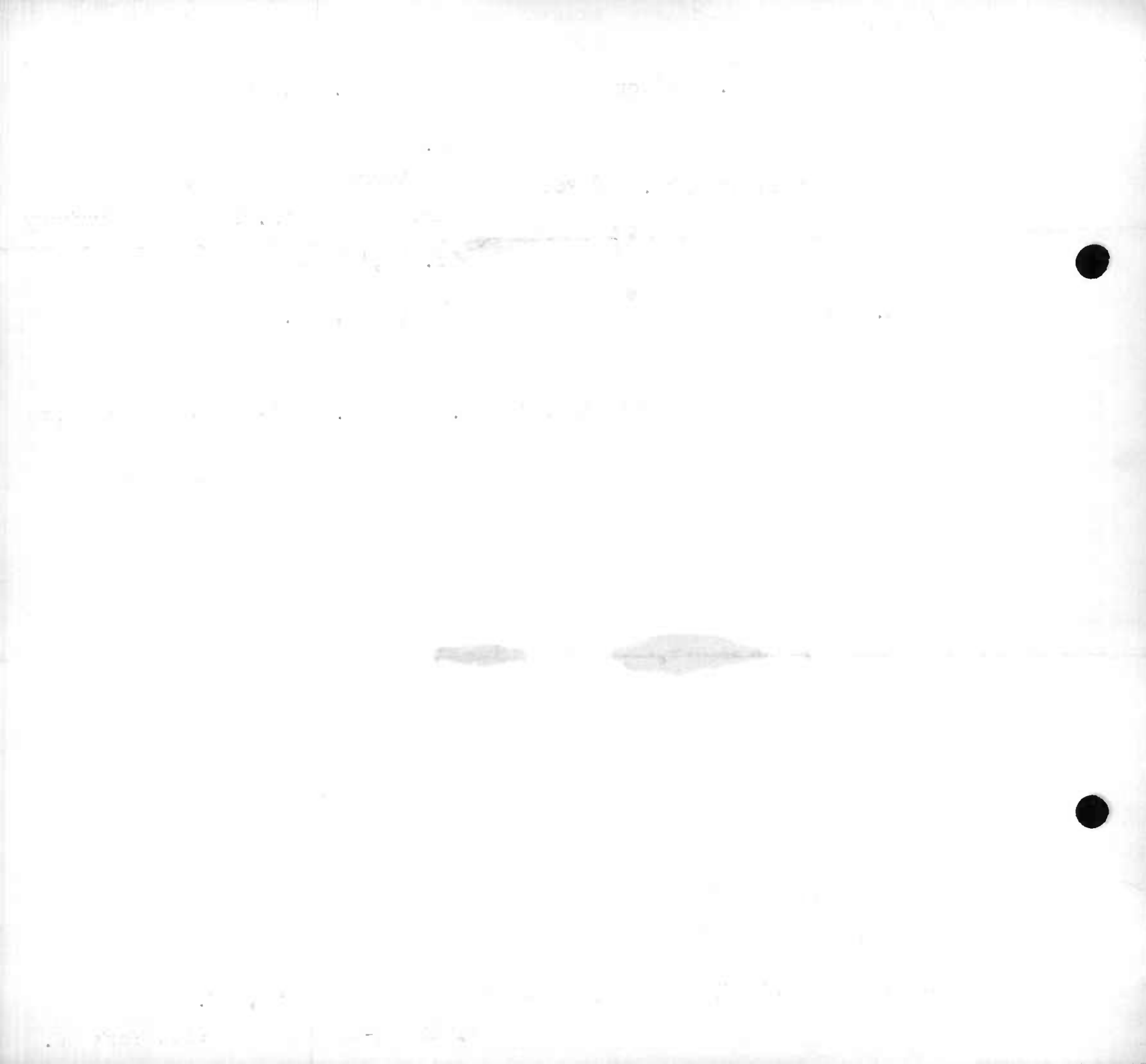
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 12209	
7-455 71 12209		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FLEMING, ELWOOD FRANKIS		12 27 71 12:45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL		A. STATE MARYLAND WICOMICO			
40		C. CITY OR TOWN SALISBURY		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1100 RIVERSIDE DRIVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01 25 02	9. AGE (in years) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOTEL OWNER		10B. KIND OF BUSINESS OR INDUSTRY HOTEL		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Wm. S. K. FLEMING		14. MOTHER'S MAIDEN NAME Susie Bradley			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 265402828		17. INFORMANT BALTO MD 212209 ST AGNES HOSP RECORDS WILKENS & CATON Mrs. Minnie C. Fleming, Salisbury, Md. (Wife)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 410.91 CAUSE OF DEATH Heart Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 12/27 19 71 to 12/27 19 71 that (X) (we) lost saw the deceased alive on 12/27/ 19 71 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (IX) (We) (did) (not) view the body after death.					
23A. SIGNATURE Lemuel A. Vargas Jr. M.D.		23B. DATE SIGNED 12-27-71		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS Baltimore, Maryland		23E. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, P.A., Salisbury, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/71		24C. NAME OF CEMETERY or CREMATORY Wicomico Memorial Park	
24D. LOCATION Salisbury, Wicomico, Maryland		24E. NAME OF REGISTRAR			
24F. NAME OF REGISTRAR JAN 4 1972		24G. NAME OF REGISTRAR			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">71 12210</span>	
BIRTH NO. <span style="float: left;">M-460</span>					
1. NAME OF DECEASED (Type or Print) <b>Emery E. Moeller</b>		2. DATE AND HOUR OF DEATH <b>Dec. 29, 1971</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>00 Ambassador Apts. # 201</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1201</b>			
		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>Ambassador Apts. 39th &amp; Canterbury</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 24, 1906</b>	
				9. AGE (In years last birthday) <b>75</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Comm. Merchant</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216 10 3894</b>		17. INFORMANT <b>Mrs. Clara L. Moeller Ambassador Apts</b>	
		ADDRESS			
18. <b>410-7 I</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenic, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b>					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-30 1962</b> to <b>12-28 1971</b> that (I) (we) lost saw the deceased alive on <b>11-24 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Franklin E. Leslie</b>				23B. DATE SIGNED <b>12-29-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRANKLIN E. LESLIE MD</b>				23D. ADDRESS <b>3501 St Paul St. Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<b>Entombment</b>		<b>12/31/71</b>		<b>Lorraine Mausoleum</b>	
				<b>Woodlawn, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Valerie E. Taylor</b>		25C. FUNERAL DIRECTOR <b>MITCHELL-WIEDEFELD</b>	
				ADDRESS <b>6500 York Rd.</b>	

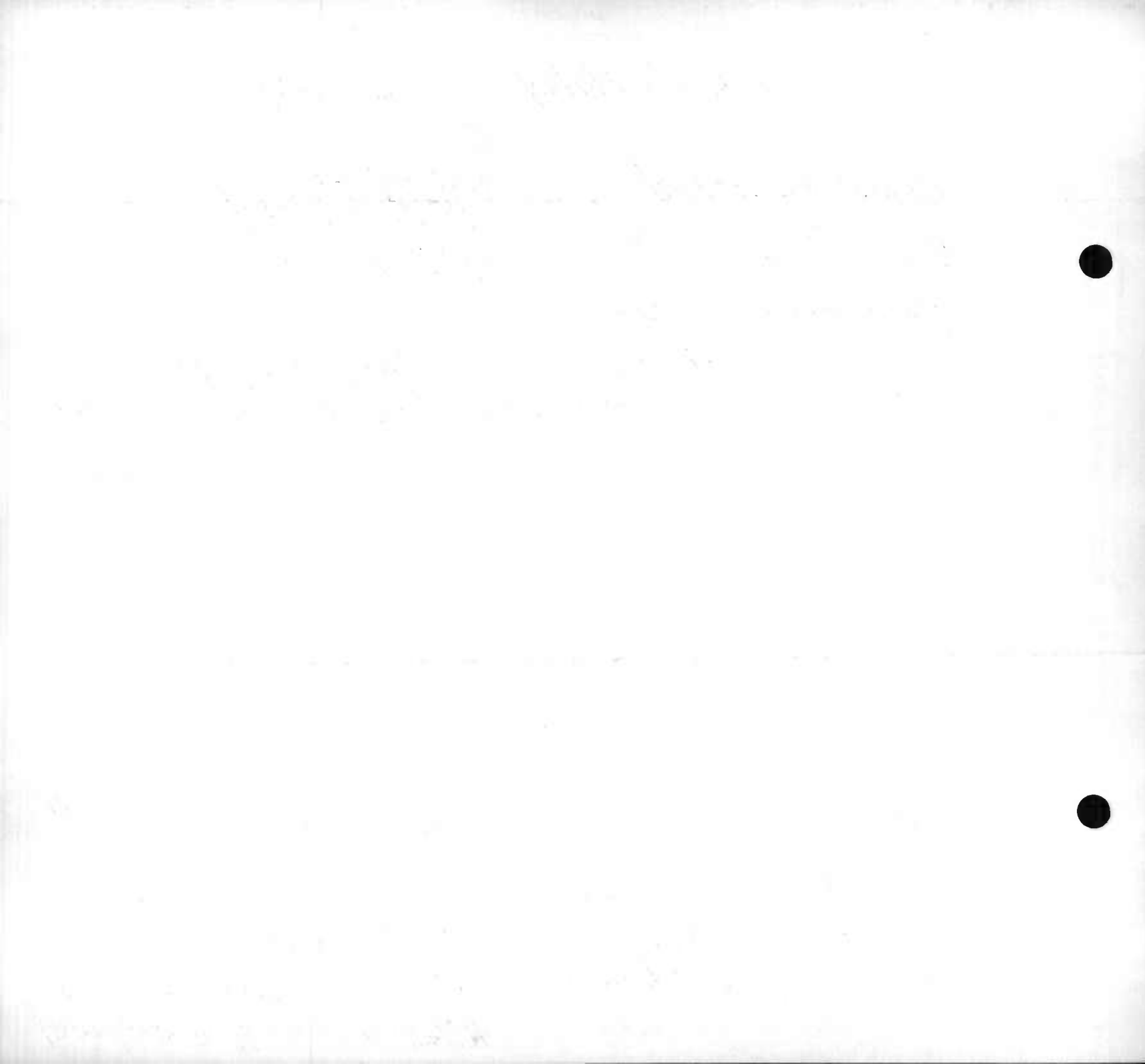




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400		71 12211		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12211	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Frank J. Haley</i>				2. DATE AND HOUR OF DEATH <i>12/25/71</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Conn</i> B. COUNTY <i>V06</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial</i>				C. CITY OR TOWN <i>Ridgefield</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <i>105 Nod Hill Rd</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/23/1898</i>	9. AGE (in years last birthday) <i>73</i>	10. Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Lawyer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>law</i>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Wm. Haley</i>				14. MOTHER'S MAIDEN NAME <i>Mary McKenna</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>130 10 136 A</i>		17. INFORMANT <i>Mrs. Florence M. Haley</i>		ADDRESS <i>same</i>	
18. <i>44091</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Arterio sclerotic Vascular Disease</i>				<i>Years</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> 19 <i>71</i> to <i>Dec</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>Dec 16</i> 19 <i>71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Robert R. Kent M.D.</i>				23B. DATE SIGNED <i>12/27/71</i>			
23C. PHYSICIAN'S NAME (Type) <i>Robert R. Kent</i>				23D. ADDRESS <i>6701 N. Charles St.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/29/71</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Woodlawn Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 4 1972</i>		25B. NAME OF REGISTRAR <i>Robert R. Kent</i>		25C. FUNERAL DIRECTOR <i>Michael Woodfield Home</i>		ADDRESS <i>6500 York Rd</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>G-610</b></span> <span><b>71 12212</b></span> </div>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		<b>REG. NO. 71 12212</b>	
<b>1. NAME OF DECEASED</b> (Type or Print) <b>GRUBB, ISABELLE</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>12/30/71 8:30 A.M.</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>Johns Hopkins Hospital</b> <b>33</b>		<b>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</b> A. STATE <b>MD</b> B. COUNTY <b>HOWARD</b> <b>6300</b>			
<b>5. SEX</b> <b>FC</b>		<b>6. RACE</b> <b>W</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>N.W.</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> 		<b>8. DATE OF BIRTH</b> <b>12-01-17</b>	
<b>13. FATHER'S NAME</b> <b>BROADBENT, Joseph</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>RHODES, SARA</b>		<b>9. AGE (in years last birthday)</b> <b>54</b>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>USA</b>	
<b>17. INFORMANT</b> <b>MR. JOSEPH GRUBB 5166 EVANGELINE WAY</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>18. 174X I</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Pulmonary Obstruction</b> <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Metastatic Carcinoma in Lung</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Carcinoma of Breast</b> <b>(C)</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <b>11/2/5/71</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>Path. Ex of Femur</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>No</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <b>No</b>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from Dec 13 1971 to Dec 30 1971 that (I) (we) lost saw the deceased alive on 12/30 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>D.M. Haines</b>		<b>23B. DATE SIGNED</b> <b>12/30/71</b>		<b>23C. PHYSICIAN'S NAME (Type)</b> <b>D.M. Haines</b>	
<b>23D. ADDRESS</b> <b>601 N. Broadway</b>		<b>23E. DEGREE</b>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>1/3/72</b>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Crestlawn</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>R 40 Howard County, Md.</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 4 1972</b>			
<b>25B. NAME OF REGISTRAR</b> <b>John F. Kelly, M.D.</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Howard County Funeral Home</b>		<b>ADDRESS</b> <b>4112 Columbia Pike</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

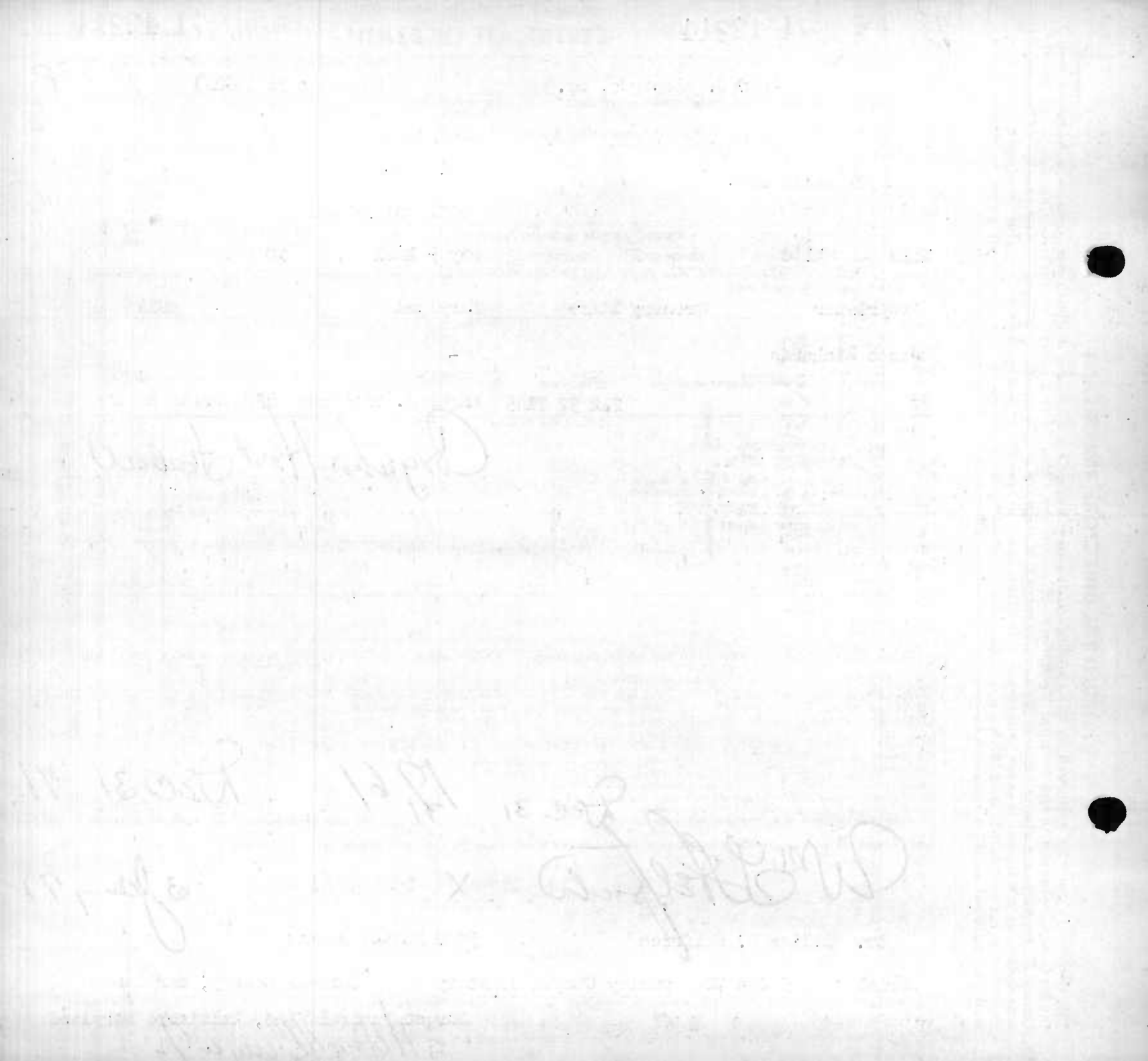
BIRTH NO.		Baltimore City Health Department		REG. NO.	
D-250 71 12213		71 12213			
1. NAME OF DECEASED (Type or Print) <b>DAWSON William E</b>			2. DATE AND HOUR OF DEATH <b>Dec. 29, 1971, 1:54<sup>45</sup> A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION Memorial Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3409 Chestnut Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <del>SEPA</del> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07-22-03</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool &amp; Die Maker</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Machine Shop</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>
13. FATHER'S NAME <b>UNKNOWN</b>			14. MOTHER'S MAIDEN NAME <b>EFFIE E. BERRY</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1922 -</b>			16. SOCIAL SECURITY NO. <b>049103529</b>		17. INFORMANT <b>Pearl M Fitzgerald Finksburg Md</b>
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarct</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCULD</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ASCULD</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-19-71</b> 19__ to <b>12-29-71</b> 19__ that (I) (we) last saw the deceased alive on <b>12-29-71</b> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <b>12-29-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAIRO RAMIREZ</b>				23D. ADDRESS <b>MD UNION Memorial Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>3 JAN 72</b>		24C. NAME of CEMETERY or CREMATORY <b>Holly Hills Mem Garden</b>	
24D. LOCATION <b>Balto Md</b>		24E. NAME of REGISTRAR <b>Burgess</b>		24F. FUNERAL DIRECTOR <b>Burgess</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Burgess</b>		25C. FUNERAL DIRECTOR <b>Burgess</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 12214	
<div style="display: flex; justify-content: space-between;"> <span>B-263 71 12214</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
John C. Richards, Sr.		December 31 1971 10 <sup>30</sup> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
4301 Falls Road		Maryland		2714	
00		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		4301 Falls Road			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 5 1881	90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Proprietor		Grocery Store		Maryland	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?			
Jacob Richards		USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		212 32 7145		Edgar A. Richards	
				4324 Falls Road	
18. 427.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Dec 31 1971 to Dec 31 1971, that (I) (we) last saw the deceased alive on Dec 31 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Dr. William G. Helfrich		3 January 72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. William G. Helfrich		5006 Roland Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5 Jan 72		Wesley Chapel Cemetery	
				Carroll County, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 4 1972		Burgee Funeral Home, Baltimore		ADDRESS	
				Maryland	
				BY: Herman Burgee Jr	

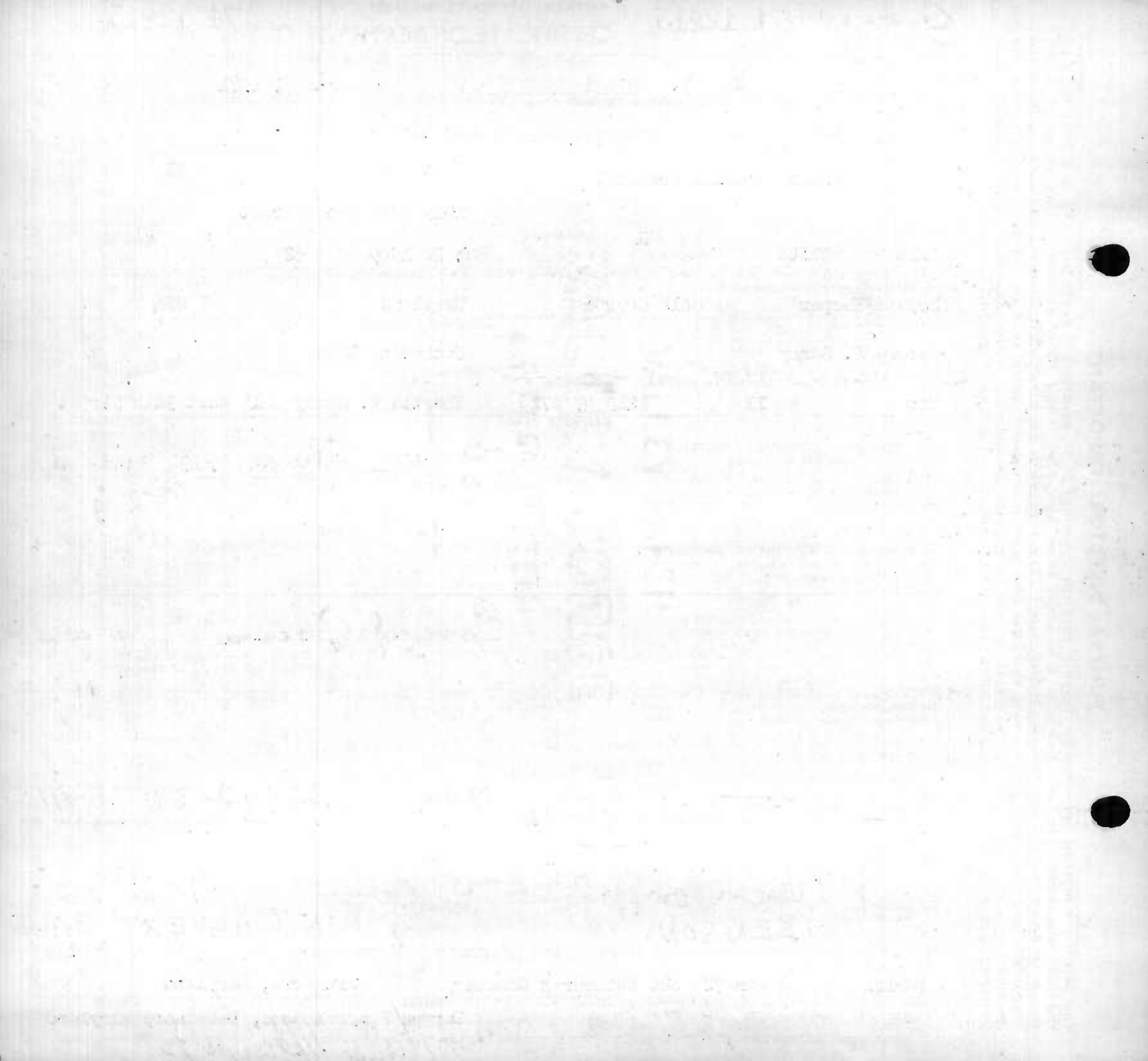




FUNERAL DIRECTOR: IMPORTANT

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G-500 71 12215				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12215	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
LEO T. GANEY				December 31 1971		10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland		B. COUNTY 1307	
44 Union Memorial Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1015 West 38th Street			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 22 1909	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Greens Keeper		Golf Course		Maryland		USA	
13. FATHER'S NAME George T. Ganey				14. MOTHER'S MAIDEN NAME Catherine Shea			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes WW II		219 07 8716		Theetta K. Ganey 1015 West 38th Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II				Coronary thrombosis		minutes	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) 2 Previous M.I.'s		2 yrs 1 1/2 yrs	
				(C)			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7-12-1966 to 12-31-1971, that (I) (we) last saw the deceased alive on 11-16-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
W P Benson, Jr M.D.				1-3-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
W BENSON				3506 N. CALVERT BALT			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)	
Burial		4 Jan 72		New Cathedral Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 4 1972		R. R. Felt, M.D.		Burge Funeral Home, Baltimore Maryland			



# FUNERAL DIRECTOR: IMPORTANT

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K.340		71 12216		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12216	
1. NAME OF DECEASED (Type or Print) <b>TODD ALLEN KEITHLEY</b>				2. DATE AND HOUR OF DEATH <b>DEC. 30, 1971 9 15 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GEN. HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>HARFORD</b> C. CITY OR TOWN <b>HAYRE de GRACE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>RD # 2 Box 207</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-9-64</b>		9. AGE (In years last birthday) <b>7</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>- NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMAS E. KEITHLEY</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH MC MILLEN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>MR. THOMAS E. KEITHLEY</b> ADDRESS <b>WEBSTER VILLAGE RD 2 Box 207</b>			
18. <b>324 X 1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SEPTICEMIA</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>SEVERE DIFFUSE PNEUMONIA</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>SPASTIC PARAPLEGIA 2° TO PREVIOUS ENCEPHALITIS</b> (C) <b>PSYCHEMOTOR RETARDATION</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>PSYCHEMOTOR RETARDATION</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>DEC. 28</b> 19 <b>71</b> to <b>DEC. 30</b> 19 <b>71</b> , that (I) (we) last saw the deceased alive on <b>DEC. 30</b> 19 <b>71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Nelson R. de Lara</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>DEC. 30, 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>NELSON R. DE LARA</b>				23D. ADDRESS <b>SOUTH BALTIMORE GEN. HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/3/1972</b>		24C. NAME of CEMETERY or CREMATORY <b>ANGEL HILL CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>HAYRE DE GRACE HARFORD MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>W. Embrey</b>		ADDRESS <b>Harford, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-460 71 12217		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12217	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Raymond B. Miller		December 30, 1971 1:10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  00 4204 Roland Avenue Baltimore, Maryland			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4204 Roland Avenue 21211		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sep 12, 1896	9. AGE (In years last birthday) 75 yrs.	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor		10B. KIND OF BUSINESS OR INDUSTRY University	11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Charles H. Miller			14. MOTHER'S MAIDEN NAME Brownell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No - - -		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mary O. Miller 4204 Roland Ave. 21211	
18. <u>412.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypertensive ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2.5 yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/2/45</u> 19 to <u>12/30/71</u> 19 that (I) (we) lost saw the deceased alive on <u>12/29/71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <u>Francis W. Gluck</u>				23B. DATE SIGNED <u>12/31/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Francis W. Gluck</u>				23D. ADDRESS <u>100W University PKwy</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 1/3/72		24C. NAME OF CEMETERY or CREMATORY Green Mount Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR <u>Barbara J. Miller</u>		25C. FUNERAL DIRECTOR ADDRESS Donovan Funeral Home 3818 Roland Ave.	

1900, Dec 11

A. J. C.

1900, Dec 11

A. J. C.

1900, Dec 11

1900, Dec 11

A. J. C.

1900, Dec 11

1900, Dec 11

1900, Dec 11

1900, Dec 11

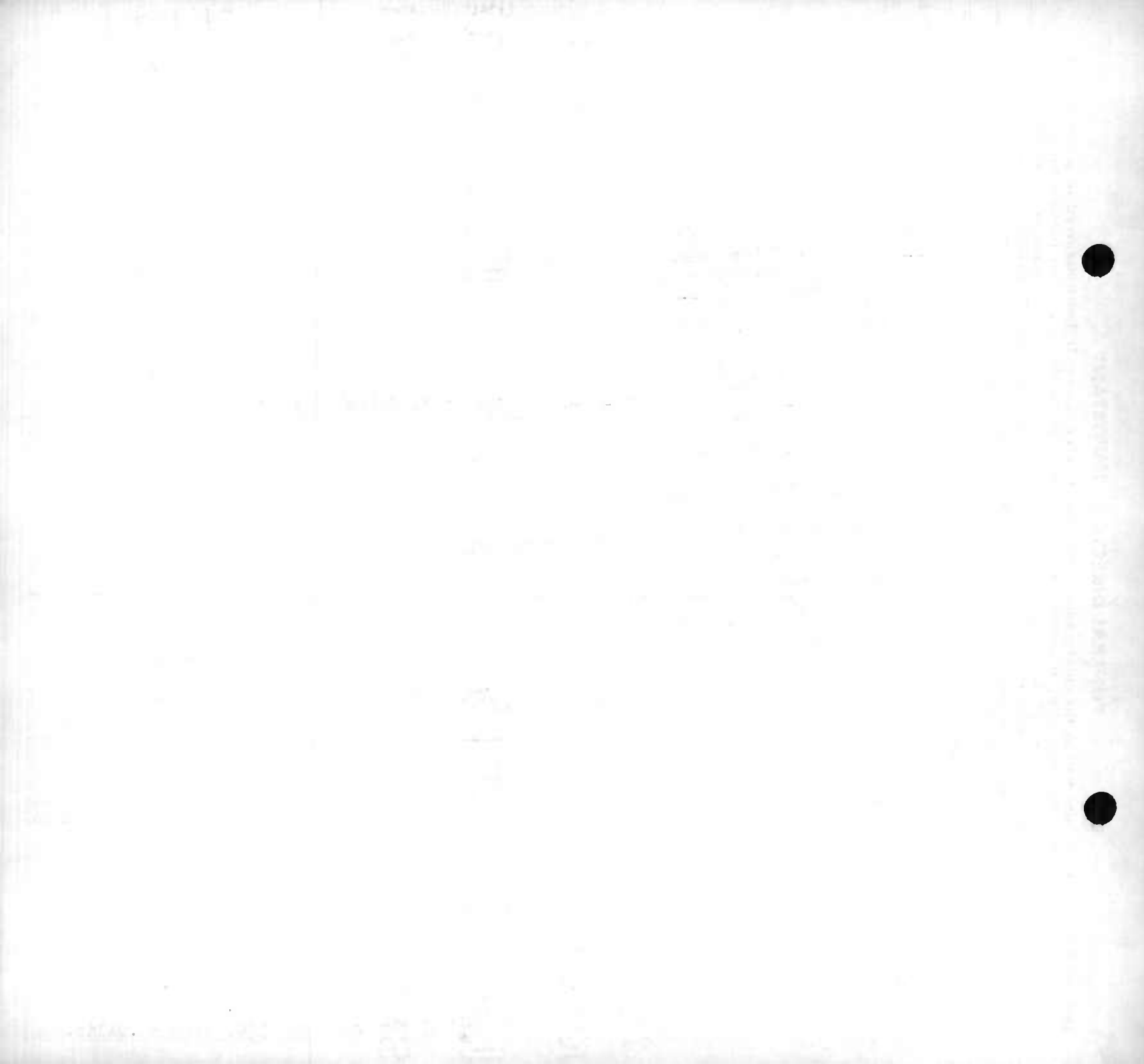
1900, Dec 11

1900, Dec 11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 2em;">S-200</span> <span style="font-size: 2em;">71 12218</span>				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="font-size: 2em;">71 12218</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">CATHERINE M. SCHUCH</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">DECEMBER 31, 1971</span> <span style="font-size: 1.5em;">8 P.</span> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.5em;">901</span>			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">44</span>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">UNION MEMORIAL HOSPITAL</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <span style="font-size: 1.2em;">Female</span> 6. RACE <span style="font-size: 1.2em;">W</span> White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">08-10-1900</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">71</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Homemaker</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">--</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">JAMES LUNDY</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MARY CONNOR</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No <span style="font-size: 1.2em;">--</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-22-7400B</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Joseph J. Schuch (Husband) Same</span>			
18. <span style="font-size: 1.5em;">174X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">CARDIORESPIRATORY FAILURE</span>  (B) <span style="font-size: 1.2em;">CARCINOMATOSIS</span> DUE TO, OR AS A CONSEQUENCE OF:  (C) <span style="font-size: 1.2em;">BREAST CANCER</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12/4</span> 19 <span style="font-size: 1.2em;">71</span> to <span style="font-size: 1.2em;">12/31</span> 19 <span style="font-size: 1.2em;">71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12/31</span> 19 <span style="font-size: 1.2em;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.5em;">Cesar Villardo</span>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">12/31/71</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">CESAR VILLARDO INTERN</span>				23D. ADDRESS <span style="font-size: 1.2em;">33rd and Calvert ST.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">1/4/72</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Dulaney Valley Memorial Gardens</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Cockeysville, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 4 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Seitz</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Eugenia K. Seitz</span> <span style="font-size: 1.2em;">Seitz Funeral Home 5209 York Rd. Balto.</span>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

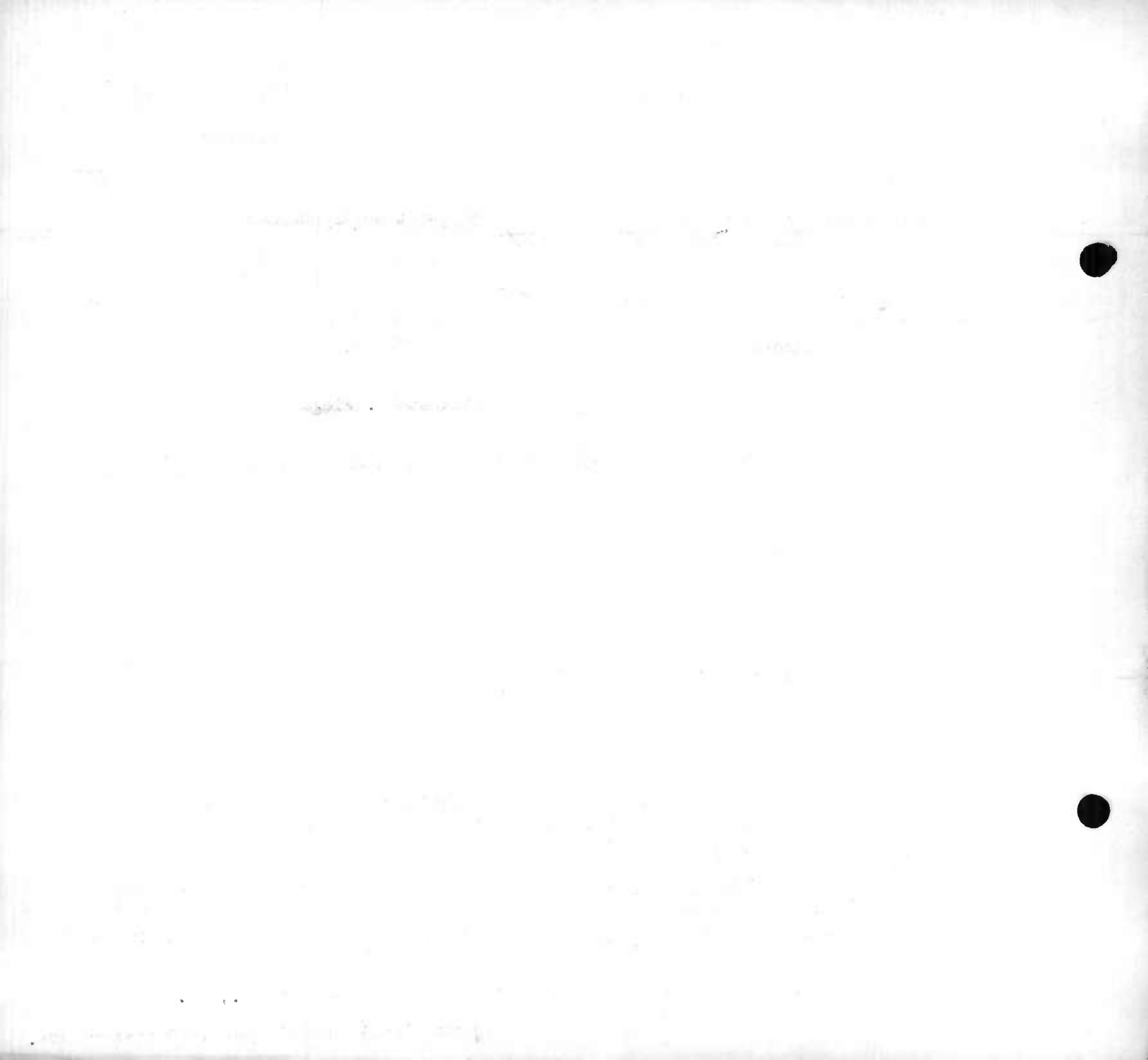
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12219</u>	
W-46 71 12219		BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		E DNA M. WILBUR		2. DATE AND HOUR OF DEATH DEC 31, 1971 1435 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND 38		A. STATE MD BALTIMORE CITY 2402			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 401 WARREN AVE			
5. SEX FEM	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-98	9. AGE (In years last birthday) 73	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Mary R. McHugh 1520 Northbayne Road 21212	
18. 154.0 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ADENOCARCINOMA OF RECTO-SIGMOID METASTATIC TO NECK, GENERALIZED		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: METASTASIS.			
(C) _____					
II		ACUTE MYOCARDIAL INFARCTION.			
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 01/11/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DEFORMED VISCUS		20A. AUTOPSY? (Yes or No) YES NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from DEC 1 19 71 to DEC 31 19 71 that (1) (we) last saw the deceased alive on DEC 31 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anthony J. Raneri MD				23B. DATE SIGNED Dec 31, 1971	
23C. PHYSICIAN'S NAME (Type) ANTHONY J. RANERI MD		23D. ADDRESS 225 GREENE ST BALTIMORE, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/72		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore City, Maryland		24E. STATE Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR P. J. J. J. J.		25C. FUNERAL DIRECTOR Academy Funeral Homes 130 E. Folt Ave 21230	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

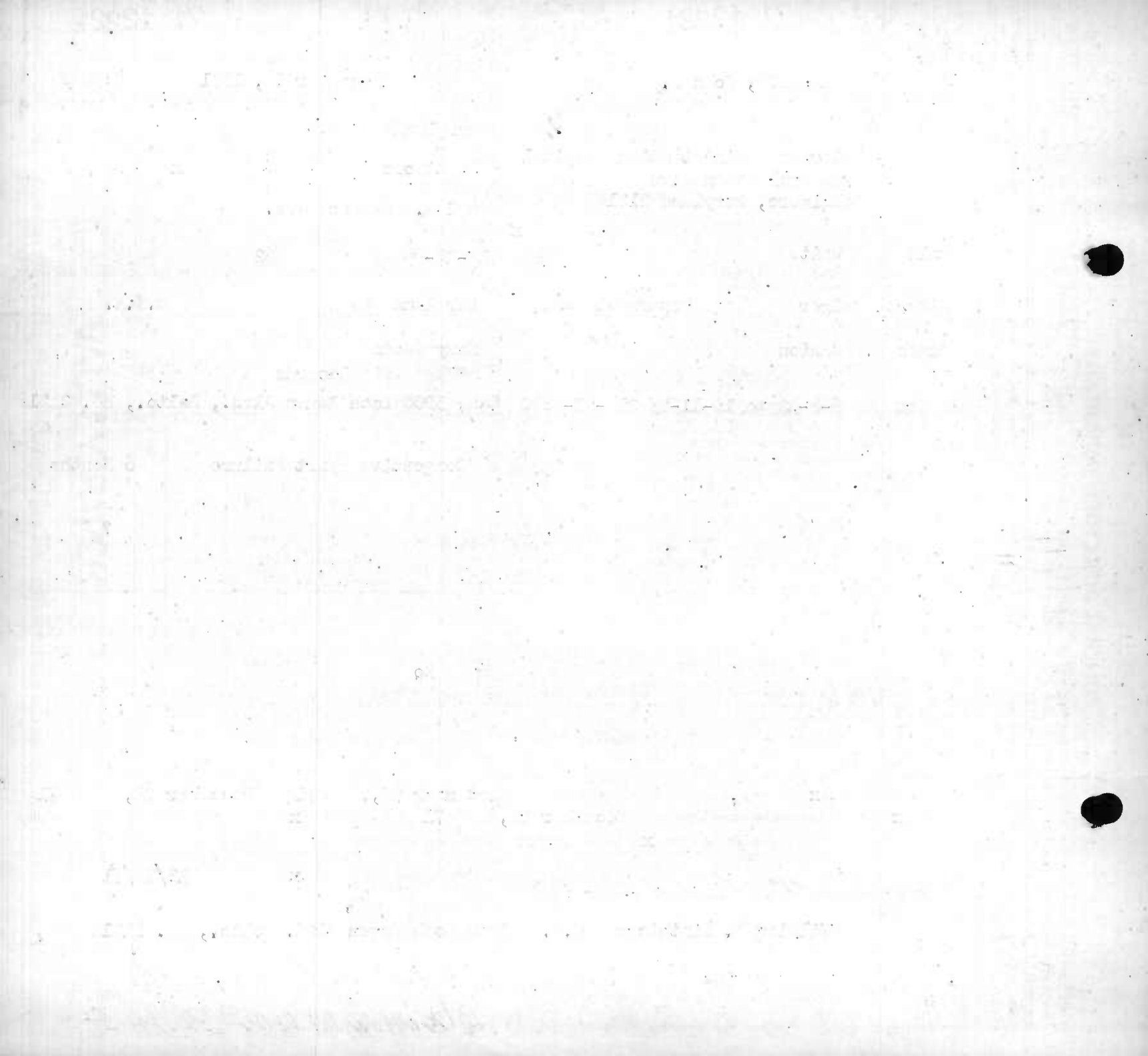
7-200		71 12220		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12220	
1. NAME OF DECEASED (Type or Print) <u>Fiene, Charles</u>				2. DATE AND HOUR OF DEATH <u>12/31/71</u> <u>11 45</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CORANADA NURSING CENTER</u> <u>4017 Liberty Heights Ave</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>349 West Woodlynn Road</u>			
5. SEX <u>Male</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-09</u>	9. AGE (in years last birthday) <u>62</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-05-3403</u>		17. INFORMANT <u>Elizabeth M. Fiene</u> ADDRESS <u>ASame</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last.) <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8/25/71</u> 19 to <u>12/31/71</u> 19 that (I) (we) last saw the deceased alive on <u>12/31/71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Howard S. Sennalind</u>				23B. DATE SIGNED <u>1/1/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Howard Sennalind</u>				23D. ADDRESS <u>1801 Glenview Rd. Park Rd.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/4/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Brudzinski</u>		ADDRESS <u>Funeral Home 1407 Eastern Ave.</u>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 12221	
<div style="display: flex; justify-content: space-between;"> <span>M-550 71 12221</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <b>MANNION, John F.</b>			2. DATE AND HOUR OF DEATH <b>December 28, 1971 4:50 P M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>602</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd</b> <b>Baltimore, Maryland 21218</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>Male</b>			6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>12-17-09</b>			9. AGE (In years last birthday) <b>62</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kitchen Helper</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Restraunt</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>James J. Mannion</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Woods</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 5-4-42 to 10-11-45</b>		
16. SOCIAL SECURITY NO. <b>214-01-5620</b>			17. INFORMANT <b>Records</b> ADDRESS <b>VAH, 3900 Loch Raven Blvd., Balto., Md. 21218</b>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>(A) IMMEDIATE CAUSE Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C) ?</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>42</b> (this hospital) attended the deceased from <b>December 27, 19 71</b> to <b>December 28, 19 71</b> , that <b>40</b> (we) last saw the deceased alive on <b>December 28, 19 71</b> and that in <b>40</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>40</b> (We) (did) <b>not</b> view the body after death.					
23A. SIGNATURE <b>William R. Linthicum M.D.</b>				23B. DATE SIGNED <b>12/28/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>William R. Linthicum M.D.</b>				23D. ADDRESS <b>3900 Loch Raven Blvd. Balto., Md. 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-3-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemet.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Kelly, Md. 0 0 0</b>		25C. FUNERAL DIRECTOR <b>B. Robinsonski 2614 E. Balto. St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12222</b>	
BIRTH NO. <b>B-600 71 12222</b>				CERTIFICATE OF DEATH <b>X</b>	
1. NAME OF DECEASED (Type or Print) <b>LOUIS E BAUER</b>			2. DATE AND HOUR OF DEATH <b>29 Dec 1971 2:20 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>CAROLINA</b> B. COUNTY <b>CAROLINA</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University of Maryland Hospital</b>			C. CITY OR TOWN <b>SPRINGFIELD State Hospital</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>M</b>			6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PATIENT</b>			10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>75</b>
13. FATHER'S NAME <b>John Bauer</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Bach</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>215-56-3472</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
17. INFORMANT <b>CHART</b>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL Infarction</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12/24/71</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.) <b>Respiratory Arrest</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>12/24/71</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Aspiration</b>			(C) DUE TO, OR AS A CONSEQUENCE OF: <b>12/24/71</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Gastrointestinal Bleeding</b>			9-16-71		
19A. DATE OF OPERATION <b>12/23/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>G.I. Bleeding</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>22 Dec 1971</b> to <b>29 Dec 1971</b> that (we) last saw the deceased alive on <b>29 Dec 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Monella Koepfel MD</b>				23B. DATE SIGNED <b>29 Dec 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>TEROME KOEPPPEL MD</b>				23D. ADDRESS <b>University of Maryland Hosp.</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-31-71</b>		24C. NAME of CEMETERY or CREMATORY <b>New Catholic</b>	
24D. LOCATION <b>Old Frederick Road Baltimore</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor MD</b>		25C. FUNERAL DIRECTOR <b>11 Krouse Funeral Home 1216 S Charles St</b>			

Adm. 2/6/26

Handwritten notes at the bottom left, including "Adm. 2/6/26" and other illegible text.

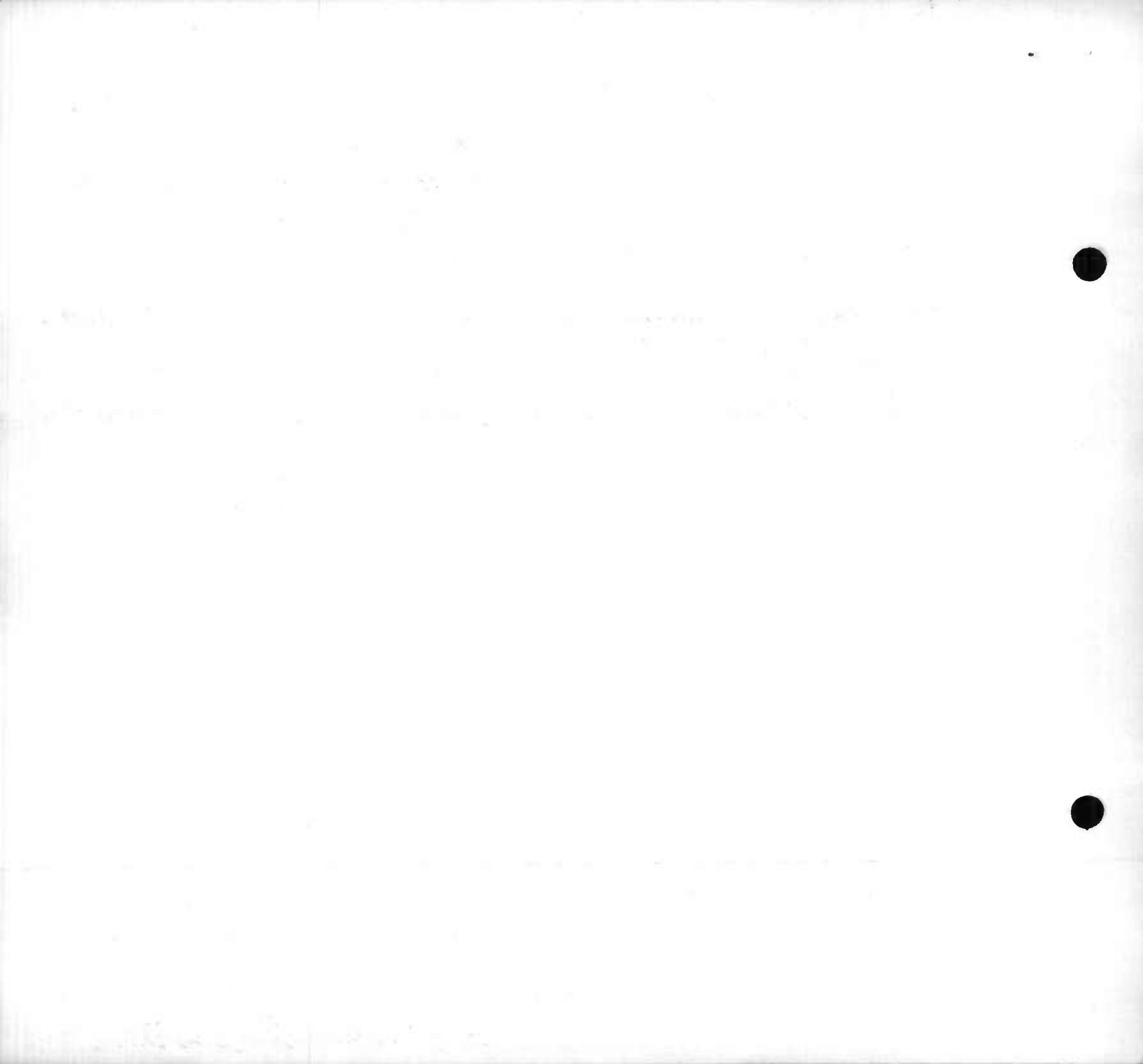
Handwritten notes at the bottom center, including "Adm. 2/6/26" and other illegible text.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-460		71 12223		BALTIMORE CITY HEALTH DEPARTMENT		X		71 12223	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>THERESA A. TAYLOR</b>						2. DATE AND HOUR OF DEATH <b>DEC 30, 1971 14:00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Md. General Hospital</b>						A. STATE <b>Md.</b>		B. COUNTY <b>Baltimore</b>	
						C. CITY OR TOWN <b>Baltimore Highlands</b>		D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES	
E. STREET AND NUMBER <b>2921 Vermont Ave Baltimore Md 21227</b>									
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/21/21</b>		9. AGE (In years last birthday) <b>50</b>		10. Under 1 To 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Health Care Admin.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alfred Valdrighi</b>				14. MOTHER'S MAIDEN NAME <b>Pearl (unmarried)</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>				16. SOCIAL SECURITY NO. <b>218-14-1439</b>		17. INFORMANT <b>Lawrence E. Taylor</b>		ADDRESS <b>Same as #4</b>	
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Pulmonary Metastasis Breast Carcinoma</b>		<b>1967 - 1971</b>	
						(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <b>10-25</b> 19 <b>71</b> to <b>DEC 30</b> 19 <b>71</b> that (1) (we) last saw the deceased alive on <b>DEC 30</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Raymond B. Elma M.D.</b>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>DEC 30, 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>BAYANI B. ELMA M.D.</b>						23D. ADDRESS <b>5355 Conynge Cr. Balt Md. 21229</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/3/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>1/3/72</b>		25C. FUNERAL DIRECTOR <b>Singleton Funeral Home, Baltimore, Md.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>71 12224</b>	
BIRTH NO. <b>B-650 71 12224</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>LOUISE BROWN</b>		2. DATE AND HOUR OF DEATH <b>12/31/71</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2005 Dennison St</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>1506</b>	
		C. CITY OR TOWN <b>Baltimore</b>	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>2005 Dennison St</b>	
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>81</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>81</b>
11. BIRTHPLACE (State or foreign country) <b>St Mary's County, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>????</b>		14. MOTHER'S MAIDEN NAME <b>Alice</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>Mrs Holly 3717 Ferndale Ave</b>	
18. <b>4/12-3</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CVA (Cerebral Hemorrhage)</b> <b>2 days</b>	
		(B) <b>Arterio-sclerotic Heart Disease</b> <b>Unknown</b>	
		(C) <b>Gen. Arterio-sclerosis</b> <b>Unknown</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/2</b> 19 <b>71</b> to <b>12/31</b> 19 <b>71</b> that (I) (we) lost saw the deceased alive on <b>12/30</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>E. E. Holt, M.D.</b>		23B. DATE SIGNED <b>1/3/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Edward E. Holt, M. D.</b>		23D. ADDRESS <b>3715 Liberty Heights Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/5/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	

The first of these is the  
 fact that the system is  
 not self-sufficient. It  
 is dependent on the  
 outside world for many  
 of its needs.

x

The second of these is the  
 fact that the system is  
 not self-sufficient. It  
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 outside world for many  
 of its needs.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 12225</u>	
BIRTH NO. <u>B-400 71 12225</u>					
1. NAME OF DECEASED (Type or Print) <u>THERESA BEALL</u>		2. DATE AND HOUR OF DEATH <u>DOROTHY 12-29-71 5:40 PM.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>NORTH CHARLES GENERAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>6840 BECLARE RD</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-27</u>	9. AGE (In years last birthday) <u>44</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>GENERAL ELECTRIC</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>HENRY BIELAMOWICZ</u>			
14. MOTHER'S MAIDEN NAME <u>AMELIA BRZOSTEK</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>217-24-0738</u>		17. INFORMANT <u>PA HOSPITAL RECORD</u> ADDRESS			
18. <u>174X I</u> CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>METASTATIC CA OF THE BREAST</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>—</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>—</u>					
19A. DATE OF OPERATION <u>12-13-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>APPROXIMATELY FOR CA OF BREAST</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12-9-71</u> 19 <u>71</u> to <u>12-29</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12-29</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Attending Physician</u>				23B. DATE SIGNED <u>12/29/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>TEODORO CARANGAL</u>				23D. ADDRESS <u>NORTH CHARLES GENERAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-3-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEM.</u>	
24D. LOCATION (City, town, or county) <u>DUNDALK, BALTO MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1972</u>			
25B. NAME OF REGISTRAR <u>John E. Kelly, R.D.</u>		25C. FUNERAL DIRECTOR <u>John W. Schuster</u>			



E152  
A 520

BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. <u>71 12226</u>	
BIRTH NO. <u>71 12226</u>									
1. NAME OF DECEASED (Type or Print) <u>CATHERINE M. EVANS (Ames)</u>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month <u>December</u> Day <u>29</u> Year <u>1971</u>		Hour <u>5:35</u> P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1346 Division Street</u>				3. DATE PRONOUNCED DEAD Month <u>December</u> Day <u>29</u> Year <u>1971</u>				Hour <u>5:35</u> P.M.	
6. SEX <u>Female</u>				7. RACE <u>Negro</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Baltimore</u>	
9. DATE OF BIRTH <u>11-7-14</u>				10. AGE (In years lost birthday) <u>57</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Harry J. Ames</u>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <u>Annie L. Ames</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, near unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO. <u>215-07-3583</u>		18. INFORMANT <u>James Evans Sr.</u>		ADDRESS <u>1346 Division</u>	
19. <u>153.0</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Carcinoma of cecum with perforation and (A) IMMEDIATE CAUSE <u>peritonitis</u> DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:					
				(C) _____ DUE TO, OR AS A CONSEQUENCE OF:					
20A. DATE OF OPERATION <u>2</u>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <u>Yes</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D. EXAMINER'S NAME (Type) <u>Charles S. Springate, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>December 30, 1971</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-4-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fahey, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton &amp; Dyett F. H.</u>		ADDRESS <u>1701 Laurens St.</u>			

TO THE SECRETARY OF THE ARMY  
FROM THE SECRETARY OF THE ARMY  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or official communication.]



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12227</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>71 12227</u>					
1. NAME OF DECEASED (Type or Print) <u>EDGERTON MARY M. (Burley)</u>		2. DATE AND HOUR OF DEATH <u>December 31, 1971 6:10 P M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIV. of MD HOSP.</u>		A. STATE <u>MD.</u>		B. COUNTY <u>1901</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>22 S GREENE ST BALTO. MD</u>		E. STREET AND NUMBER <u>308 N. Carey St.</u>			
5. SEX <u>F.</u>	6. RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-7-1908</u>	9. AGE (in years last birthday) <u>63</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Powersville, N.C.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Jerome Burley 308 N. Carey St.</u>	
18. <u>412.2 I</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u>		<u>48 hrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Dissected CVA</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>12 days</u>	
(C) <u>Hyper carotid vascular disease, CHF</u>				-	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>December 19</u> 19 <u>71</u> to <u>December 31</u> 19 <u>71</u> that (I) <u>we</u> last saw the deceased alive on <u>December 31</u> 19 <u>71</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert P. Whitehead M.D.</u>				23B. DATE SIGNED <u>December 31, 1971</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1-4-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Carver Mem. Pk.</u>	
24D. LOCATION <u>Balto, Md.</u>		24E. FUNERAL DIRECTOR <u>Robert E. Taylor, M.D.</u>		24F. ADDRESS <u>1701 - Laurens</u>	



D 250

71 12228

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12228

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John Dixon, Jr.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Maryland General Hospital

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐Month  
12Day  
31Year  
71Hour  
12:30P. M.3. DATE  
PRONOUNCED DEADMonth  
12Day  
31Year  
71Hour  
12:30P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

E. STREET AND NUMBER

2002 Mt. Royal Terrace

9. DATE OF BIRTH

2-5-61

10. AGE (in years  
last birthday)

10

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John C. Dixon, Sr.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Child

15. MOTHER'S MAIDEN NAME

Mamie Buriss

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.  
Child

18. INFORMANT

ADDRESS

Charles Dixon

19.

345.9 E 940 X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Death during epileptic seizure  
DUE TO, OR AS A CONSEQUENCE OF:complicating cerebral injury from auto  
accident

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☒ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Unknown

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Unknown

22D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

unk.

1965

22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

Unknown

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-1-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-4-72

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 4 1972

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Morton &amp; Dyett F. H. 1701 Laurens St.

N 854.0



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				REG. NO. <u>71 12229</u>			
BIRTH NO. <u>71 12229</u>				1. NAME OF DECEASED (Type or Print) <u>ROSCOE STANFIELD</u>				2. DATE AND HOUR OF DEATH <u>12/31/71</u> <u>4:30</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> 8. COUNTY <u>BALTO CITY</u>				C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIV OF MD. HOSPITAL</u> <u>38</u>				E. STREET AND NUMBER <u>1105 N. FULTON AVE</u> <u>21217</u>							
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/19/19</u>	9. AGE (In years last birthday) <u>52</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>PRESTON STANFIELD</u>				14. MOTHER'S MAIDEN NAME <u>ELLA FULLER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NO</u>				16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>LILLIE STANFIELD</u> ADDRESS <u>18 PRESSBURY ST. BALTO, MD.</u>			
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>CHRONIC RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>20 yrs</u> (B) <u>DIABETES MELLITUS</u> DUE TO, OR AS A CONSEQUENCE OF: <u>20 yrs</u> (C) <u>PNEUMONIA</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>PNEUMONIA</u>											
19A. DATE OF OPERATION <u>3/12/23</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>gangrene (R) leg</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 27</u> 19 <u>71</u> to <u>Dec 31</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Dec 31, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Kenneth V. Eden MD</u>				23B. DATE SIGNED							
23C. PHYSICIAN'S NAME (Type) <u>KENNETH V. EDEN M.D.</u>				23D. ADDRESS <u>UNIV. HOSP. BALTO MD.</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-5-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1972</u>		25B. NAME OF REGISTRAR <u>Victor E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton S. Dyett F.H.</u>		ADDRESS <u>1701-1st</u>					



D 610

71 12230

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12230

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Annie Darby

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month Day Year

12 31 71

Hour Minute  
8:25 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Bon Secours Hospital

3. DATE  
PRONOUNCED DEAD

Month Day Year

12 31 71

Hour Minute  
8:25 P.M.5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

2002

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

4-22-22

10. AGE (In years last birthday)

49

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2140 W. Baltimore St.

11. BIRTHPLACE (State or foreign country)

Georgetown, S. C.

12. CITIZEN OF

WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph Nelson

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

n/a

15. MOTHER'S MAIDEN NAME

Carolina Nelson

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

n/a/

n/a

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

John Darby 2140 W. Baltimore St.

19.

412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular  
DUE TO, OR AS A CONSEQUENCE OF: disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-1-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-5-72

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 4 1972

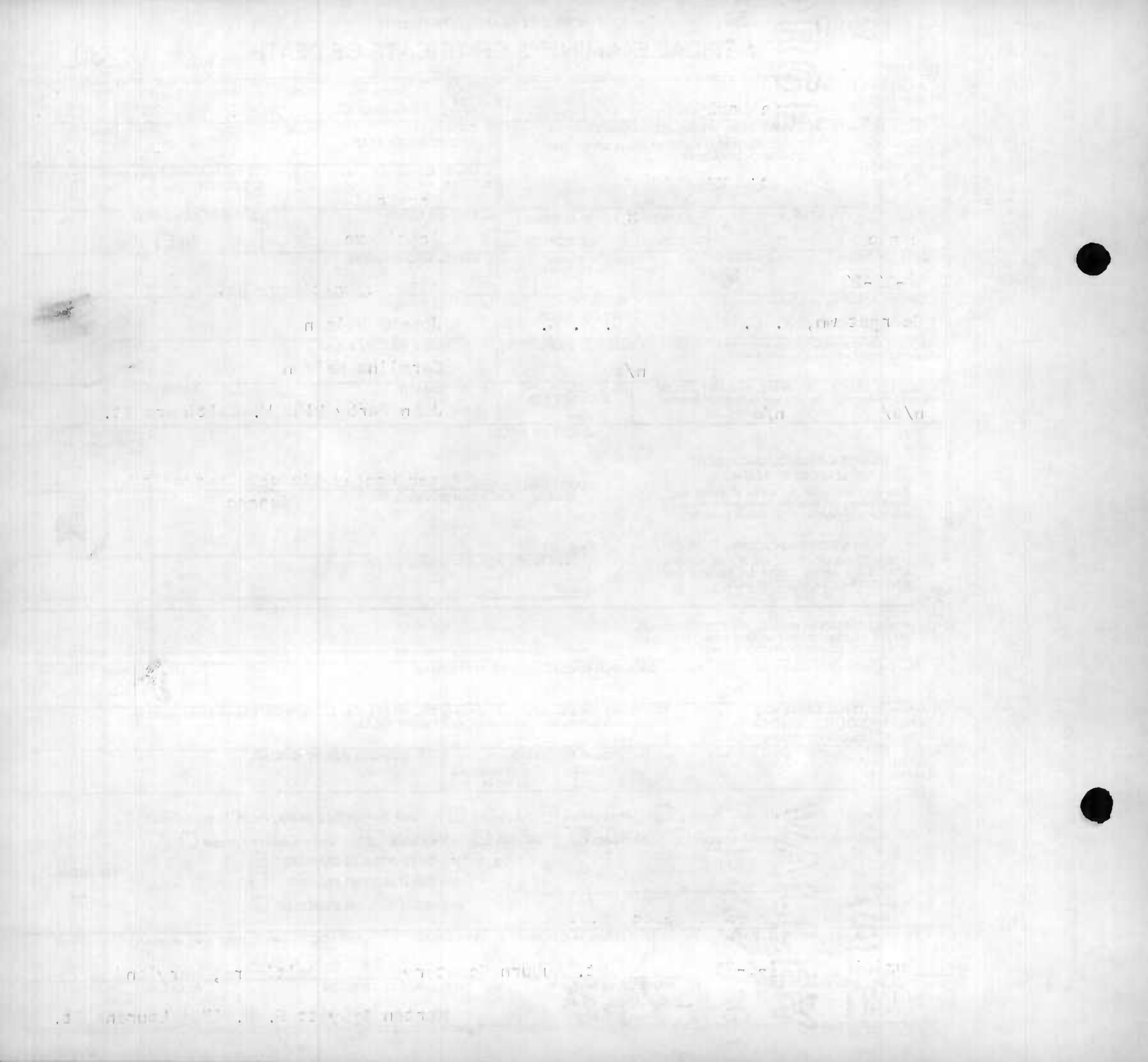
25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Morton &amp; Dyett F. H. 1701 Laurens St.





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

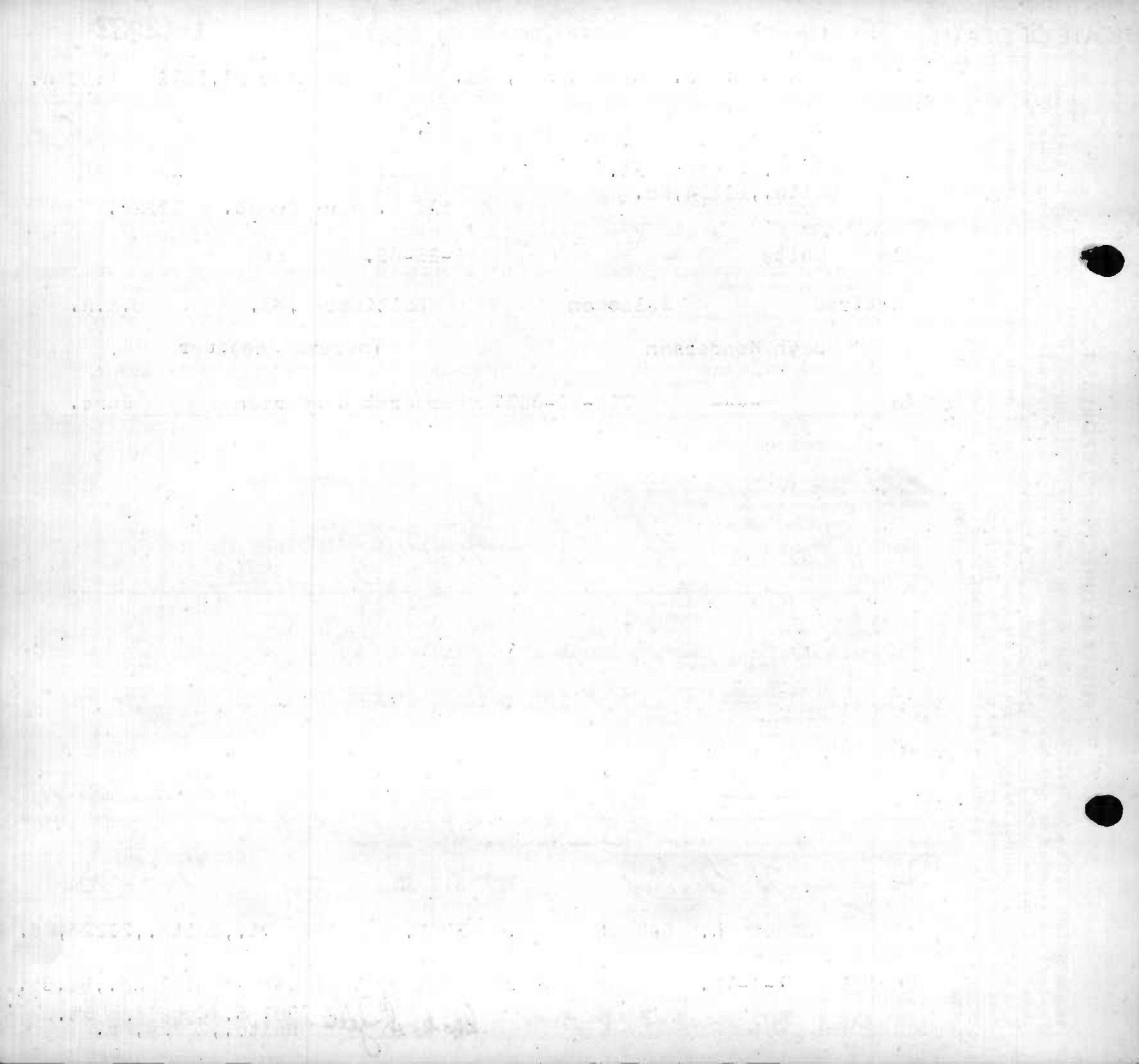
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>71 12231</b>	
71 12231		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Nettie Faulcon (NETTIE FAULCON)</b>		12/28/71 6:22 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4940 Eastern Avenue</b>		C. CITY OR TOWN	
<b>Baltimore, Maryland 21224</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b> 6. RACE <b>Negro</b>		E. STREET AND NUMBER <b>210 Center Street</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-2-1867</b> 9. AGE (In years last birthday) <b>104</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>North Carolina, Halifax</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Byrd</b>		14. MOTHER'S MAIDEN NAME <b>Minerva Byrd</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>BOH: RECORDS Baltimore, Maryland 21224</b>		ADDRESS <b>4940 Eastern Avenue</b>	
18. <b>412-3 I</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		<b>CARDIOPULMONARY ARREST 2-3 hrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>ARTERIO SCLEROTIC HEART DISEASE 710 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/28/71</b> 19 to <b>12/28/71</b> 19 that (I) (we) last saw the deceased alive on <b>12/28/71</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Sumat Srinasa, M.D.</b>		23B. DATE SIGNED <b>12/28/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>SURAT SRINASA, M.D.</b>		23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-2-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Carters Temple Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Littleton, North Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F. H.</b>		ADDRESS <b>1701 Laurens St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 12232	
BIRTH NO. 71 12232		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ALBERT J. HENDERSON, SR.		2. DATE AND HOUR OF DEATH December 31, 1971 6:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 512 S. Bouldin St. Balto., 21224, Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 26113 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 512 S. Bouldin St. # 21224.			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-05.	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Salesman		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Henderson		14. MOTHER'S MAIDEN NAME Theresa Seebauer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No ----		16. SOCIAL SECURITY NO. 218-01-8037		17. INFORMANT Margaret Henderson ADDRESS Same.	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cancer of Lung (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?	
MEDICAL CERTIFICATION 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from December 17, 1971 to December 31, 1971, that (I) (we) last saw the deceased alive on December 27, 1971 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE Jason H. Gaskel		23B. DATE SIGNED 1-3-72		23C. PHYSICIAN'S NAME (Type) JASON H. GASKEL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-4-72		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd., Ba. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972 25B. NAME OF REGISTRAR Robert E. Harker, M.D. 25C. FUNERAL DIRECTOR Charles J. Gaskel			
25D. ADDRESS 901 S. Conkling St. Balto., 21224, Md.					



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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 12233</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">ROBERT J. KOCH, Jr.</span>		<b>2. DATE AND HOUR OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span><span style="font-size: 1.2em;">12.30.71</span></span> <span><span style="font-size: 1.2em;">4.15 A M.</span></span> </div>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.1em;">SINAI HOSPITAL OF BALTIMORE INC.</span> <span style="font-size: 1.1em;">2 BELVEDERE AT GREENSPRING.</span>		<b>4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)</b> A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.1em;">Baltimore</span> C. CITY OR TOWN <span style="font-size: 1.1em;">Reisterstown</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.1em;">South Lake Way</span> <span style="font-size: 1.1em;">BELVEDERE AT GREENSPRING</span>			
<b>5. SEX</b> <span style="font-size: 1.5em;">M</span>	<b>6. RACE</b> <span style="font-size: 1.5em;">W</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">5.21.62</span>	<b>9. AGE (in years last birthday)</b> <span style="font-size: 1.2em;">9</span>
<b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <span style="font-size: 1.1em;">SCHOOL BOY</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.1em;"></span>		<b>11. BIRTHPLACE (State or foreign country)</b> <span style="font-size: 1.1em;">Maryland Delaware</span>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.1em;">U.S.A.</span>
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">ROBERT KOCH, Jr.</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">BETTY Williams</span>			
<b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <span style="font-size: 1.2em;">NO</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">NONE</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">A. WHITE</span>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">CARDIORESPIRATORY ARREST</span>  (B) <span style="font-size: 1.2em;">CNS BLEEDING</span> DUE TO, OR AS A CONSEQUENCE OF: (C) <span style="font-size: 1.2em;">APLASTIC ANAEMIA</span>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">0</span>  <span style="font-size: 1.2em;">1 hr.</span>  <span style="font-size: 1.2em;">2 yrs 9 mo.</span>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;"></span>		<b>20A. AUTOPSY? (Yes or No)</b> <span style="font-size: 1.2em;">No.</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b> <input type="checkbox"/>		<b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b> <span style="font-size: 1.2em;"></span>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <span style="font-size: 1.2em;"></span>	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour) <span style="font-size: 1.2em;"></span>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> <span style="font-size: 1.2em;"></span>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Dec 16m</span> 19 <span style="font-size: 1.2em;">71</span> to <span style="font-size: 1.2em;">Dec 30m</span> 19 <span style="font-size: 1.2em;">71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Dec 28m</span> 19 <span style="font-size: 1.2em;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Angela White</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">12.30.71.</span>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.2em;">DR. ANGELA WHITE.</span>		<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">SINAI HOSPITAL</span> <span style="font-size: 1.2em;">BELVEDERE AT GREENSPRING.</span>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">1/3/72</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Sylvan Lawn Cem.</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Greene, Chenango, New York.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JAN 4 1972</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Fisher, MD</span>		<b>25C. FUNERAL DIRECTOR</b> ADDRESS <span style="font-size: 1.2em;">W. J. Ellard Owens Mills, Md</span>			

1870-1871

South Lake 1871

1871

1871

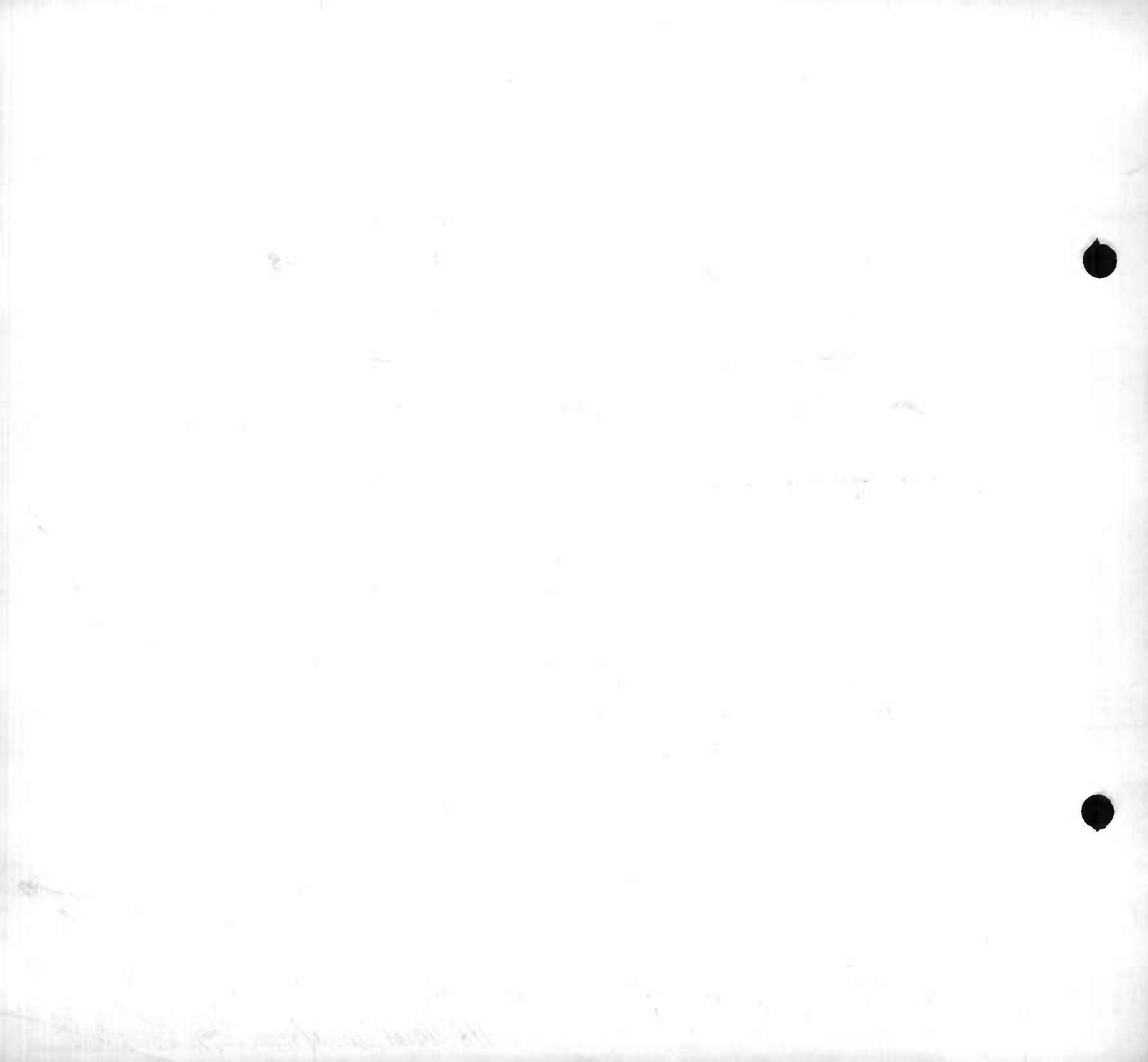
1871

W. J. Elliott's Camp 1871  
1871-1872

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12234</b>	
BIRTH NO. <b>71 12234</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>JAMES BRADSHAW</b>			2. DATE AND HOUR OF DEATH <b>12-29-71 4:45 pm</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>B</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MD. HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>919 W. LEXINGTON ST.</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-21-23</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>			11. BIRTHPLACE (State or foreign country) <b>Balt. MD.</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John Bradshaw</b>			14. MOTHER'S MAIDEN NAME <b>Ethel Bishop</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.2</b>			16. SOCIAL SECURITY NO. <b>316-18-4074</b>		
17. INFORMANT <b>WIFE Mable Bradshaw</b>			ADDRESS <b>Same</b>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF:				<b>IMMED</b>	
(B) <b>CIRCULATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF:				<b>8 1/2 hrs.</b>	
(C) <b>GASTRO-INTESTINAL BLEED</b>				<b>3 wks.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ALCOHOLIC CIRRHOSIS</b>					
19A. DATE OF OPERATION <b>0 NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-29</b> 19 <b>71</b> to <b>12-29</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12-29</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert A. Lessey</b>			23B. DATE SIGNED <b>12-29-71</b>		23C. PHYSICIAN'S NAME (Type) <b>ROBERT A. LESSEY</b>
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE <b>1/4/72</b>		24C. NAME OF CEMETERY <b>Mount Auburn Cem</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 4 1972</b>		
25B. NAME AND ADDRESS OF REGISTRAR <b>Robert E. [illegible]</b>			25C. FUNERAL DIRECTOR <b>William [illegible]</b>		





1

M-243

71 12235

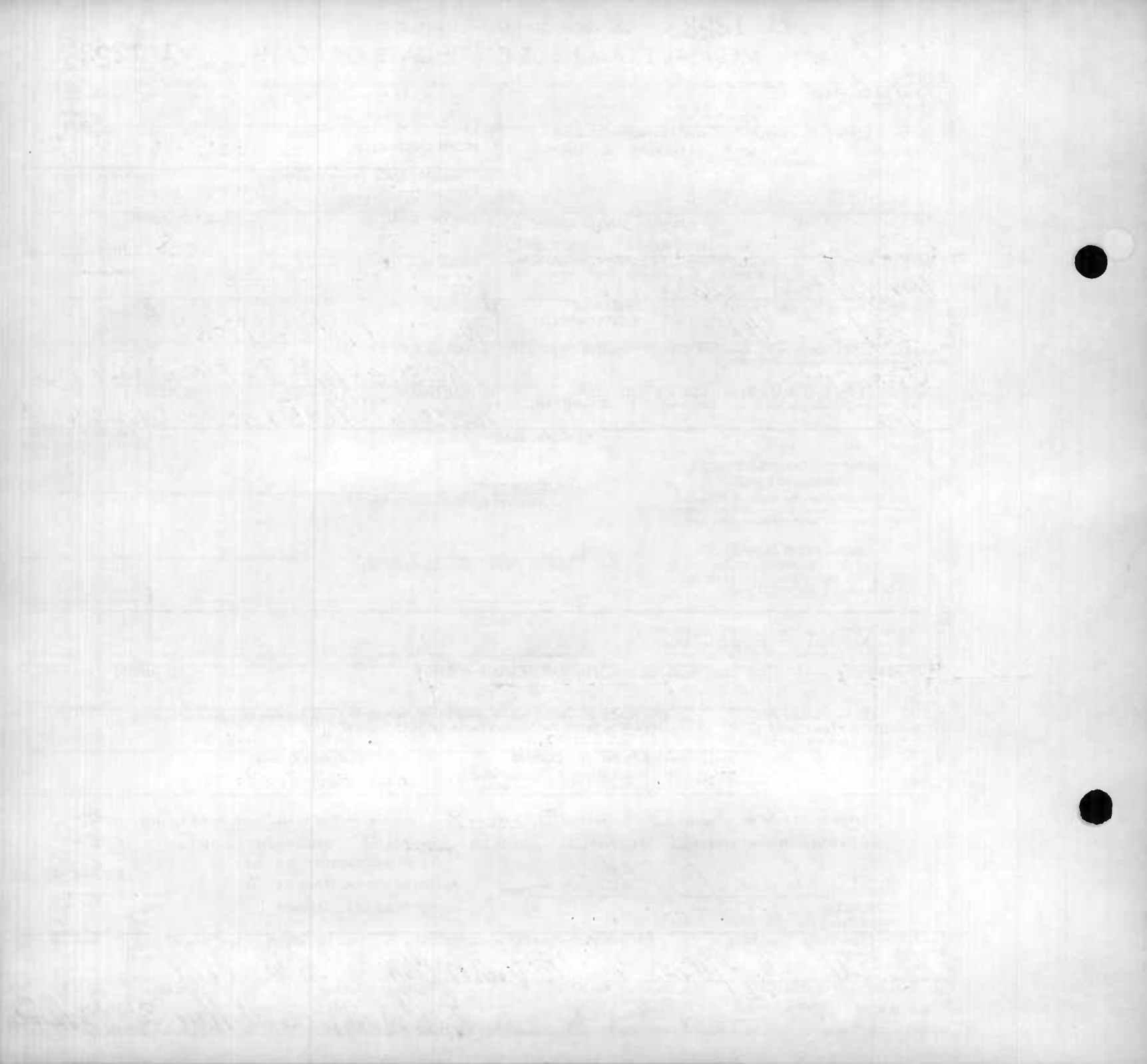
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12235  
REG. NO.

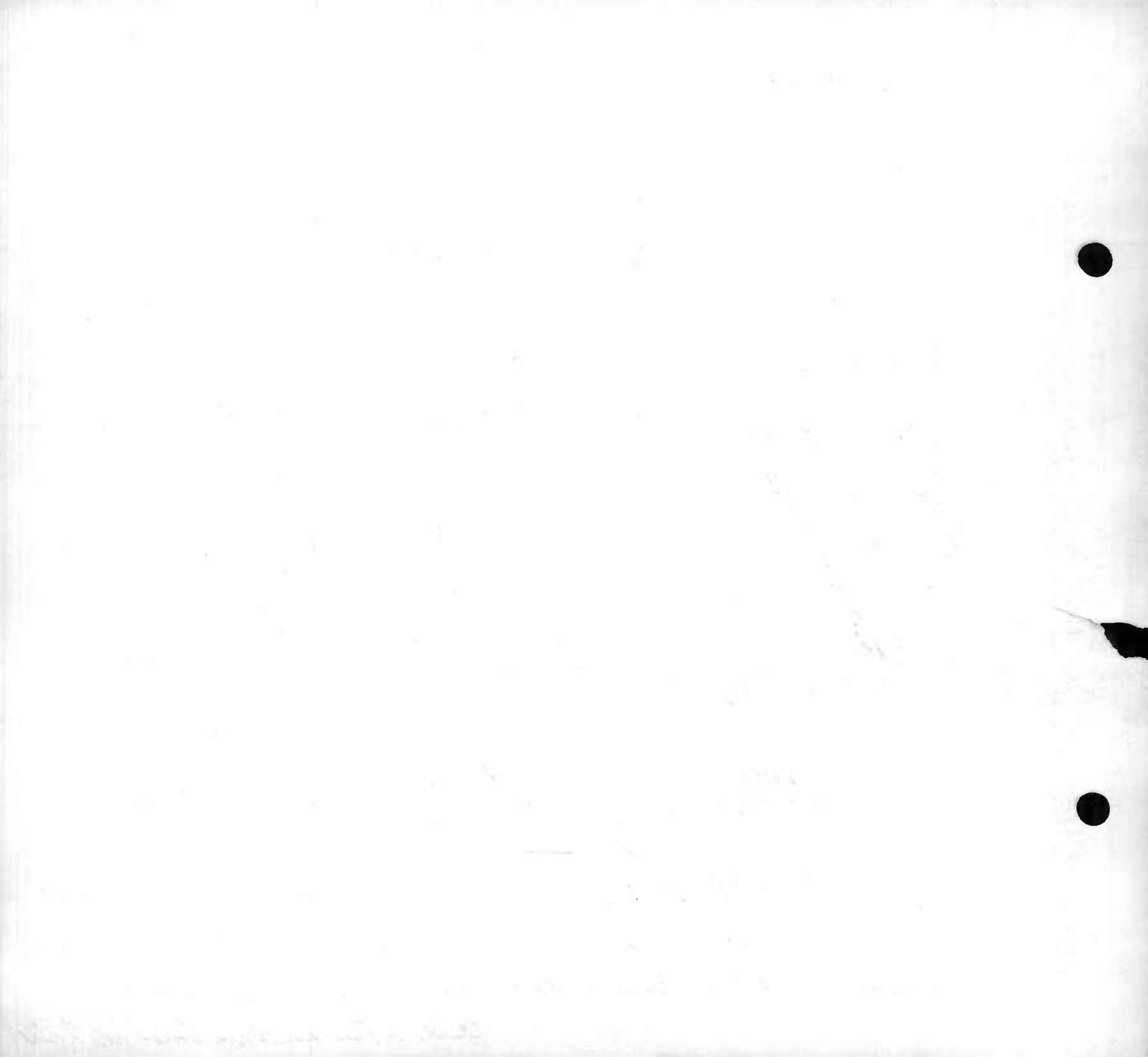
1. NAME OF DECEASED (Type or Print) IRENE McGLOTTEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> Month Day Year		3. DATE PRONOUNCED DEAD Month Day Year December 31, 1971		Hour 12:45 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1801		6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH Nov. 11, 1945		10. AGE (In years lost birthd) 26		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William McGlotten		14. MOTHER'S MAIDEN NAME Mable (McGlotten) Spriggs		15. INFORMANT Mable McGlotten		ADDRESS 247 N. Schroeder St.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mable McGlotten 247 N. Schroeder St.			
19. F 965X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) In house		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 865 W. Saratoga Street 1801			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-30-71 11:45 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE [Signature] M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/31/71	
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 1/4/1972		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balto. Md.		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 318 N. Schroeder St.	

N 875.1



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-255 71 12236		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12236	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>AMANDA H. Hickman</u>		2. DATE AND HOUR OF DEATH <u>Dec. 31, 1971</u> <u>9:30 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>604</u>		C. CITY OR TOWN <u>Baltimore (City)</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>1905 McElderry St.</u> <u>00 Baltimore, Md. 21205</u>		E. STREET AND NUMBER <u>1905 McElderry St.</u>			
5. SEX <u>F</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1889</u>	9. AGE (in years last birthday) <u>82</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>David Heller</u>		14. MOTHER'S MAIDEN NAME <u>Anna C. Schmidt</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-2740</u>		17. INFORMANT <u>Gary S. Hill, 1907 McElderry St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.) <u>Pulmonary embolus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Fracture, Right Hip</u>		DUE TO, OR AS A CONSEQUENCE OF: <u>15 days</u>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Hypertension</u>		DUE TO, OR AS A CONSEQUENCE OF: <u>Years</u>			
19A. DATE OF OPERATION <u>Dec. 17, 1971</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fr. of Right Hip</u>		20A. AUTOPSY? (Yes or No) <u>To be performed</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>1905 McElderry St., Baltimore</u>	
21D. TIME OF INJURY (APPROX.) <u>Dec 15, 1971</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Pt. fell in bedroom.</u>	
22. I certify that (1) (this hospital) attended the deceased from <u>December 15</u> 19 <u>71</u> to <u>December 31</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>December 30</u> 19 <u>71</u> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gary S. Hill, M.D.</u>		23B. DATE SIGNED <u>Dec. 31, 1971</u>			
23C. PHYSICIAN'S NAME (Type) <u>Gary S. Hill, M.D.</u>		23D. ADDRESS <u>1907 McElderry St., Baltimore 21205</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>5 JAN 72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEMETERY</u>	24D. LOCATION <u>BALTO, MD 21205</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1972</u>	25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>	25C. FUNERAL DIRECTOR <u>Charles E. Fungwa, Home, Balto, Md. 21204</u>	ADDRESS		



1

<p><b>71 12237</b></p> <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b></p>		<p><b>71 12237</b></p> <p>REG. NO.</p>	
BIRTH NO.			
<p>1. NAME OF DECEASED (Type or Print)</p> <p><b>PETER JOSEPH LONCAREVICH, Jr.</b></p>		<p>2. DATE OF DEATH</p> <p>Known <input type="checkbox"/> Month Day Year          Estimated <input checked="" type="checkbox"/> <b>Dec. 29, 1971</b> 3:00 P.M.</p>	
<p>4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>225 E. 25th Street</b></p>		<p>3. DATE PRONOUNCED DEAD</p> <p>Month Day Year Hour  <b>December 30, 1971</b> 2:15 P.M.</p>	
<p>6. SEX</p> <p>Male</p>		<p>5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <b>Maryland</b> B. COUNTY <b>1203</b></p>	
<p>7. RACE</p> <p>White</p>	<p>8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>C. CITY OR TOWN</p> <p>Baltimore</p>	
<p>9. DATE OF BIRTH</p> <p><b>Dec. 13, 1918</b></p>		<p>10. AGE (In years lost birthday)</p> <p><b>53</b></p>	
<p>11. BIRTHPLACE (State or foreign country)</p> <p><b>Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><b>USA</b></p>	
<p>14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><b>House</b></p>		<p>14B. KIND OF BUSINESS OR INDUSTRY</p> <p><b>Painter</b></p>	
<p>16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><b>No</b></p>		<p>17. SOCIAL SECURITY NO.</p> <p><b>Unknown</b></p>	
<p>13. FATHER'S NAME</p> <p><b>Peter Loncarevich, Sr.</b></p>		<p>15. MOTHER'S MAIDEN NAME</p> <p><b>Mary Lewis</b></p>	
<p>16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><b>No</b></p>		<p>17. SOCIAL SECURITY NO.</p> <p><b>Unknown</b></p>	
<p>18. INFORMANT</p> <p><b>George Loncarevich, Lakeland, Fla.</b></p>		<p>ADDRESS</p>	
<p>19. CAUSE OF DEATH</p> <p><b>Fatty metamorphosis of liver</b></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> <p><b>Chronic pancreatitis</b></p>			
<p>20A. DATE OF OPERATION</p> <p><b>2</b></p>		<p>20B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>21. AUTOPSY? (Yes or No)</p> <p><b>yes</b></p>			
<p>22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>22D. TIME OF INJURY (APPROX.)</p> <p>(Month) (Day) (Year) (Hour)</p>		<p>22E. INJURY OCCURRED</p> <p>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	
<p>22F. HOW DID INJURY OCCUR?</p>			
<p>23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D.</p> <p>EXAMINER'S NAME (Type)</p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p> <p>DATE SIGNED <b>12/31/71</b></p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p><b>Burial</b></p>		<p>24B. DATE</p> <p><b>1/3/71</b></p>	
<p>24C. NAME OF CEMETERY or CREMATORY</p> <p><b>St. Luke's Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State)</p> <p><b>Cumberland, Md.</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p><b>JAN 5 1972</b></p>		<p>25B. NAME OF REGISTRAR</p> <p><b>William G. Kight</b></p>	
<p>25C. FUNERAL DIRECTOR</p> <p><b>William G. Kight</b></p>		<p>ADDRESS</p> <p><b>Cumberland, Md.</b></p>	

71-15537

71-15537

Dec 13, 1918

Postmaster

Postpaid

House

Relator

Post Office

Unknown

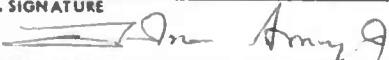
George Washington, 1800

St. James' Cemetery, Cambridge

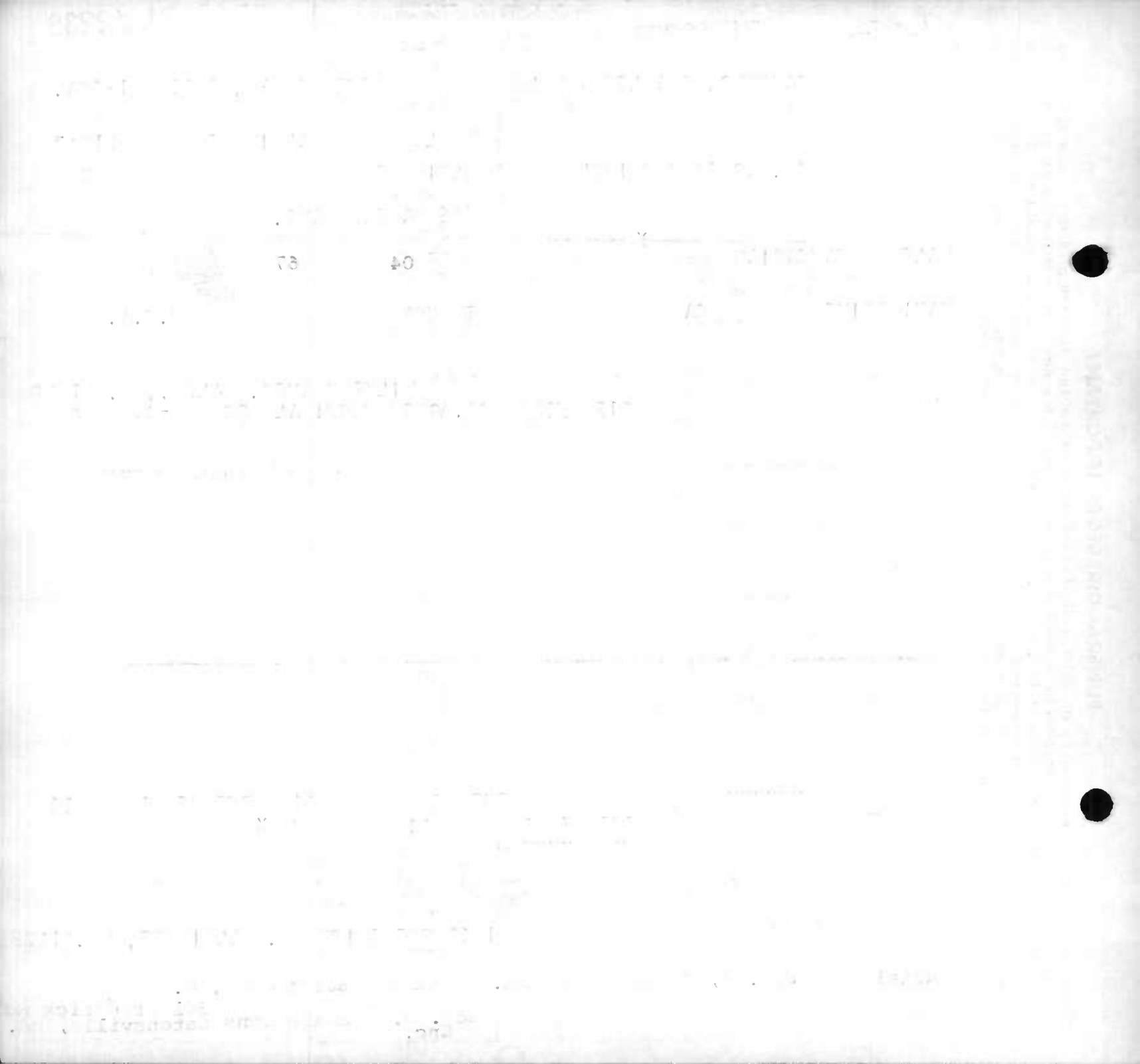
1800, 1800, 1800

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">71 12238</span>	
BIRTH NO. <span style="float: left;">G-352</span>		71 12238	
1. NAME OF DECEASED (Type or Print) <b>GANOUNG, CHARLES ARNOLD</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 30, 1971 1:15A.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b> <span style="font-size: 2em; float: left;">40</span>		A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> <span style="float: right;">21207</span>	
		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>6616 HARFORD AVE.</b>	
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>06 25 04</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAXI DRIVER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CAB</b>	9. AGE (In years last birthday) <b>67</b>
11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213205744</b>	
17. INFORMANT <b>WILKENS AVES. BALTO., MD. 21229</b>		ADDRESS <b>ST. AGNES HOSPITAL RECORDS-CATON &amp;</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASHD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia Rt base</b>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASHD</b>	
		(C) _____	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(X)</del> <del>(X)</del> <del>(X)</del> <del>(X)</del> attended the deceased from <b>DECEMBER 28</b> 19 <b>71</b> to <b>DECEMBER 30</b> 19 <b>71</b> that (I) <del>(X)</del> last saw the deceased alive on <b>DECEMBER 30</b> 19 <b>71</b> and that in <del>(my)</del> <del>(X)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(X)</del> <del>(X)</del> <del>(X)</del> view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED <b>12/30/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Adnan M. Sunmug</b>		23D. ADDRESS <b>1011 FREDERICK RD. BALTIMORE, MD. 21228</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Jan. 3, 72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem. Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>Edw. S. MacNabb Sons</b>	
		ADDRESS <b>301 Frederick Rd Catonsville, Md.</b>	

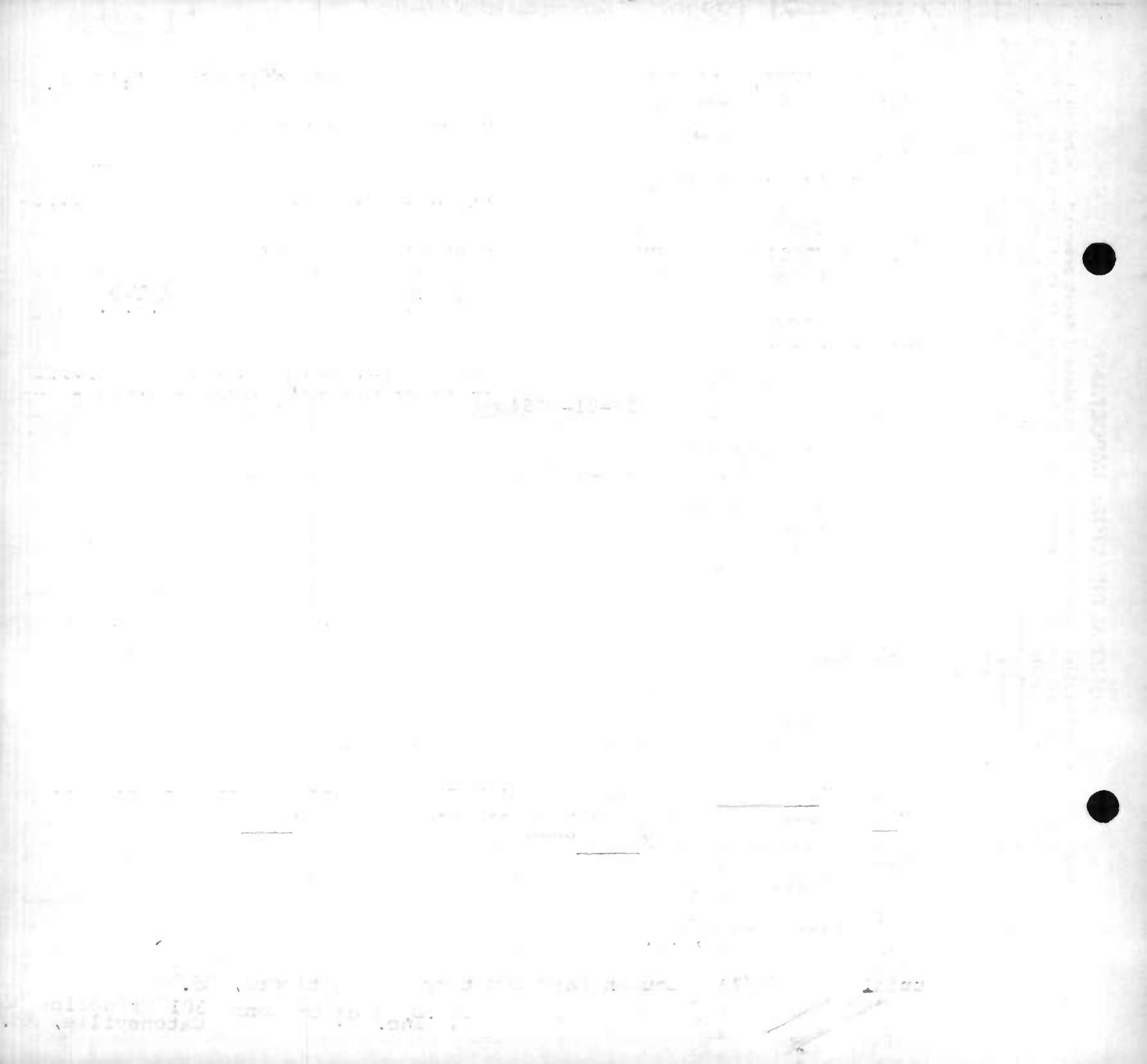






This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

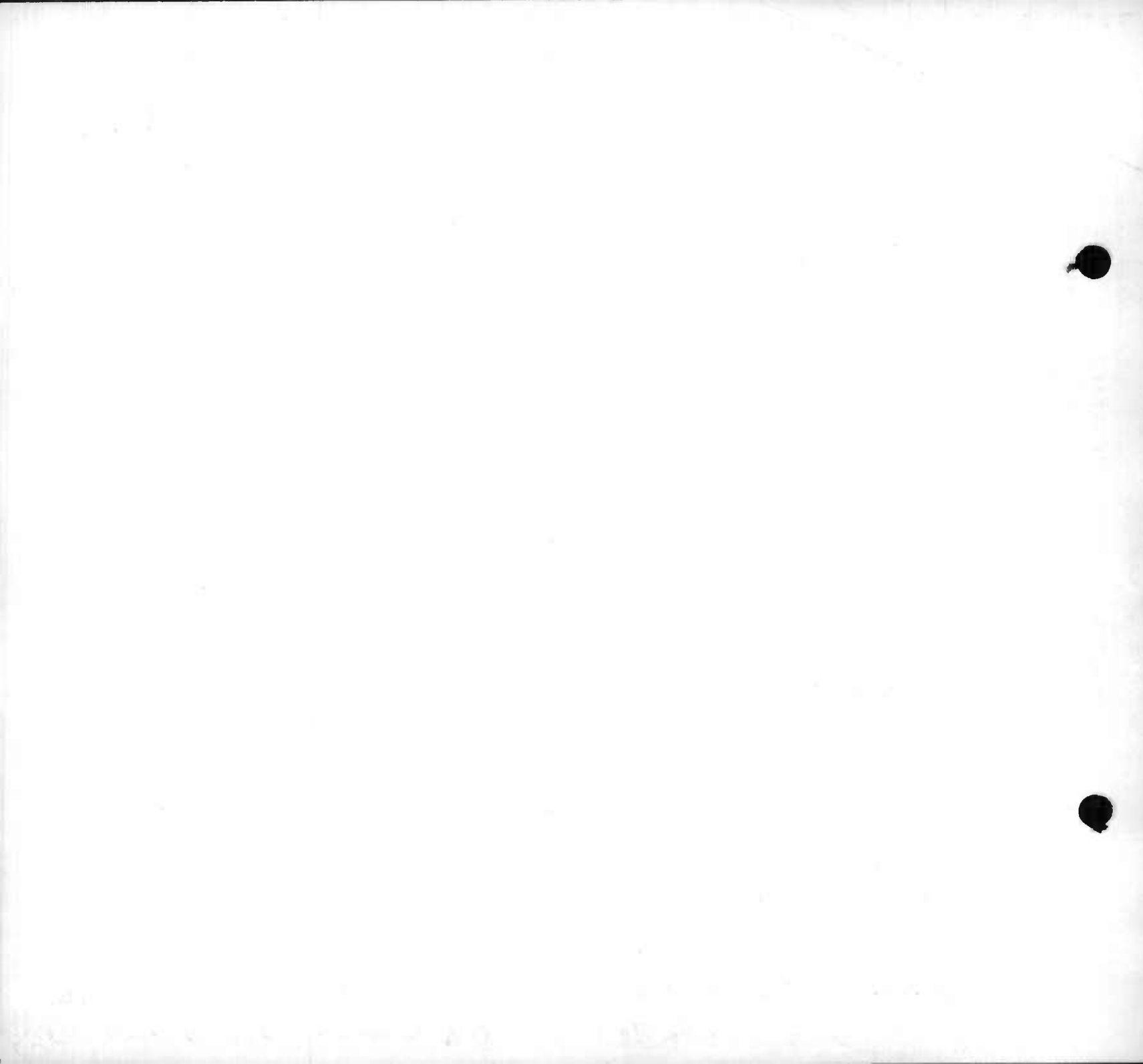
BIRTH NO. <u>U-613</u>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>71 12239</u>	
1. NAME OF DECEASED (Type or Print) <u>URBEITUS, MARGARET</u>				2. DATE AND HOUR OF DEATH <u>DECEMBER 31, 1971</u>   <u>4:45 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST AGNES HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>44 DUNGARRIE ROAD</u> <u>21228</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/04/96</u>	9. AGE (In years last birthday) <u>75</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>ANTHONY WINCES</u>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-01-0264D</u>		17. INFORMANT <u>BALTIMORE, MARYLAND</u> ADDRESS <u>21229 ST AGNES HOSPITAL CATON &amp; WILKENS AVE</u>			
18. <u>410.91725019</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary artery disease - 5 days</u> <u>ASCVD - Atrial fibril 5 yrs</u> <u>Dichloro methanes 7 yrs</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary artery disease - 5 days</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD - Atrial fibril 5 yrs</u> (C) <u>Dichloro methanes 7 yrs</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <u>DECEMBER 27</u> 1971 to <u>DECEMBER 31</u> 1971 that (X) (we) last saw the deceased alive on <u>DECEMBER 31</u> 1971 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>JOSE APTER, M.D.</u>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS				23E. MED. DIRECTOR		23F. STAFF PHYS.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/4/72</u>		<u>Loudon Park Cemetery</u>		<u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		25B. NAME OF REGISTRAR <u>Edw. B. MacNabb Sons</u>		25C. FUNERAL DIRECTOR <u>Edw. B. MacNabb Sons</u>		25D. ADDRESS <u>301 Frederick Rd Catonsville, Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-120 71 12240				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12240	
1. NAME OF DECEASED (Type or Print) <i>Eaves, Geraldine</i>				2. DATE AND HOUR OF DEATH <i>0627 hr 12/24/71</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University Hospital 38</i>				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>MD</i> B. COUNTY <i>2710</i>			
5. SEX <i>F</i> 6. RACE <i>N</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				8. DATE OF BIRTH <i>4/10/28</i>		9. AGE (in years last birthday) <i>43</i>	
10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>				11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>unknown</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i>				16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT ADDRESS	
18. <i>53771</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>Sepsis, septic shock, renal shut down</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Enterocutaneous fistula</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Gastro-jejuno-colic fistula</i> (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>12 Dec 71</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Gastro-entero-colic fistula</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>11/27/71</i> 19 <i>71</i> to <i>12/23</i> 19 <i>71</i> that (1) (we) last saw the deceased alive on <i>12/23</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Robert W. Wilensky MD</i>				23B. DATE SIGNED <i>12/23/71</i>		23C. PHYSICIAN'S NAME (Type) <i>ROBERT WILANSKY MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>				24B. DATE <i>12-27-71</i>		24C. NAME OF CEMETERY or CREMATORY <i>HARMONY MEMORIAL PARK</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 5 1972</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>		25C. FUNERAL DIRECTOR <i>R &amp; R Funeral Service</i>	
24D. LOCATION <i>Landover</i>				24E. LOCATION <i>Landover</i>		24F. LOCATION <i>Md.</i>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12241

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lawrence P. Bryant Jr.

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

December 30, 1971

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Provident Hospital (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

December 30, 1971

3:15 A. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1537

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

1-2-1966

10. AGE (In years  
last birthday)

5

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3116 Gwynn Falls Parkway

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Lawrence P. Bryant Sr.

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

student

14B. KIND OF BUSINESS OR INDUSTRY

Public School

15. MOTHER'S MAIDEN NAME

Cynthia McNeil

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Mr. Lawrence P. Bryant Sr. 3116 Gwynns

19.

466 X I

CAUSE OF DEATH

Falls Pkw

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Acute bronchitis and bronchiolitis

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE with early bronchopneumonia  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
Yes22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)Charles S. Springate M.D.  
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 30, 1971

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-4-1972

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 5 1972

25B. NAME OF REGISTRAR

Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR

NUTTER FUNERAL HOME 3035 W. NORTH AV

ADDRESS

2-9-1972 - Completion of cause of death on a pending medical examiner death certificate.  
C. Springate, M.D.

HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 12242	
BIRTH NO. 71-200271 12242				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>BOBBY GIRL JONES</b>		2. DATE AND HOUR OF DEATH <b>12/12/71 12:25 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>38 UNIVERSITY HOSP</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>ANNE ARUNDEL</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY HOSP</b>		C. CITY OR TOWN <b>TOWN</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>B</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>11/29/71</b>		9. AGE (in years last birthday) <b>12</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAYO POST OFF</b>	
11. BIRTHPLACE (State or foreign country) <b>MAYO MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>—</b>		14. MOTHER'S MAIDEN NAME <b>LEONA JONES</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>SAME - MAYO POST OFF.</b>	
18. CAUSE OF DEATH <b>731.41</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PREMATURITY</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>12/12</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INTEST OBSTRUCTION</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> 19 <b>71</b> to <b>12/12</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12/12</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Waldman</b>		23B. DATE SIGNED <b>12/12/71</b>		23C. PHYSICIAN'S NAME (Type) <b>WALDMAN</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12-20-71</b>		24C. NAME OF CEMETERY or CREMATION <b>ANATOMY BOARD OF MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>D-260</b></span> <span><b>71 12243</b></span> </div>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		<b>REG. NO. 71 12243</b>	
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>CARL DOZIER</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>12-16-71 1:23 a.m.</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY HOSPITAL 38 BALTIMORE MARYLAND</b>		<b>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</b> A. STATE <b>MARYLAND</b> B. COUNTY <b>5300</b> <b>ROSEWOOD, MARYLAND</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>OWING MILLS, MARYLAND</b>			
<b>5. SEX</b> <b>M</b>	<b>6. RACE</b> <b>N</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10-23-68</b>	<b>9. AGE (in years lost birthday)</b> <b>8</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
<b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>INFANT</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>-</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>UNKNOWN</b>	
<b>13. FATHER'S NAME</b> <b>JOHN DOZIER</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>UNKNOWN</b>			
<b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Ailary Spence</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>343/1</b>		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BILATERAL PNEUMONIA 2 weeks</b> (B) <b>STATIC QUADRIPLEGIA 8 yrs.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ENCEPHALOPATHY SEIZURE DISORDER 8 yrs.</b>			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b> <input type="checkbox"/>		<b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b>		<b>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</b>	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 12-1-71 to 12-16-71 that (I) (we) last saw the deceased alive on 12-15-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Ailary Spence MDCB</b>				<b>23B. DATE SIGNED</b> <b>12-16-71</b>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>AILARY SPENCE</b>		<b>23D. ADDRESS</b> <b>UNIVERSITY HOSPITAL</b>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b>		<b>24B. DATE</b> <b>12-20-71</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>UNIVERSITY MEDICAL SCHOOL</b>	
<b>24D. LOCATION</b> (City, town, or county) (State)		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 5 1972</b>			
<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Spence</b>		<b>25C. FUNERAL DIRECTOR</b> <b>MORTUARY SERVICE - BCD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 12244</u>	
N-140 71 12244		BIRTH NO. <u>71-22043</u>	
1. NAME OF DECEASED (Type or Print) <u>Baby boy Newbill</u>		2. DATE AND HOUR OF DEATH <u>12. 3. 71</u> <u>3<sup>10</sup></u> <u>A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1205</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 Univ. of Md. Hosp</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>311 E Lanvale Street</u>	
5. SEX <u>M</u>	6. RACE <u>Color</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-3-71</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>25</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Wyatt</u>		14. MOTHER'S MAIDEN NAME <u>Mary Newbill</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
18. <u>778.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Premature</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Premature</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Premature</u> (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>25 min</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12-3-71</u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>12-3-71</u> to <u>12-3-71</u> that (1) (we) last saw the deceased alive on <u>12-3-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>H. MURATOSHI</u>		23B. DATE SIGNED <u>12. 3. 71</u>	
23C. PHYSICIAN'S NAME (Type) <u>H. MURATOSHI</u>		23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12-30-71</u>	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <u>UNIVERSITY MEDICAL SCHOOL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR		ADDRESS <u>MORTUARY SERVICE - BCD</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

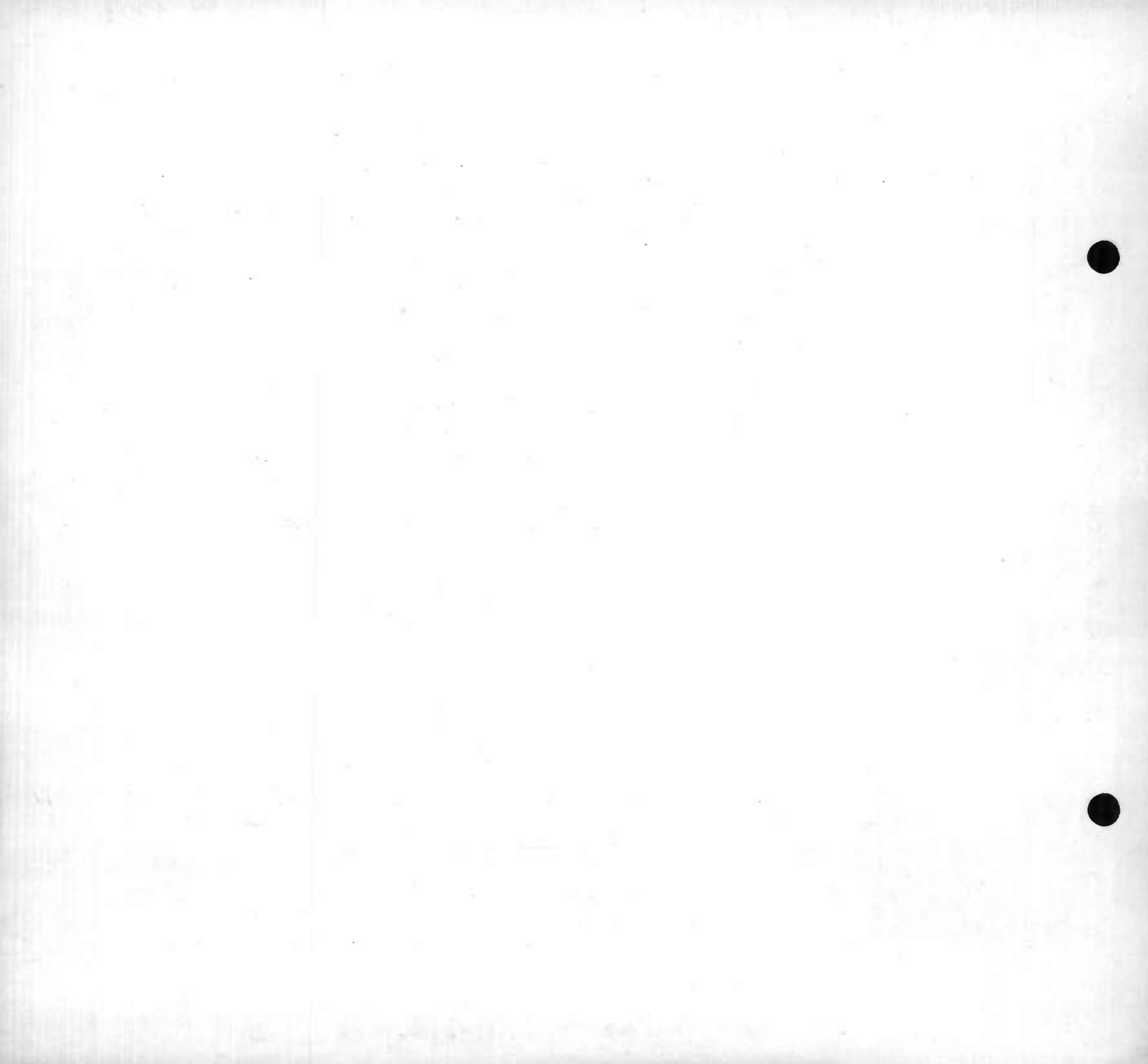
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 12245	
W-300 71 12245					
BIRTH NO. 71-21151			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) BABY BOY WHITE			2. DATE AND HOUR OF DEATH 12/18/71 5 30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY 1602		
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIV HOSP			C. CITY OR TOWN BALT		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M			6. RACE B		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 12/17/71
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME CUSSIE WHITE		9. AGE (in years last birthday) 1 23 23
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) MD
17. INFORMANT MOTHER			12. CITIZEN OF WHAT COUNTRY? USA		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PREMATURITY (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/17/71 19 71 to 12/18 19 71 that (I) (we) last saw the deceased alive on 12/18 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mr. Waldman			23B. DATE SIGNED 12/18/71		23C. PHYSICIAN'S NAME (Type) WALDMAN MD
24A. BURIAL CREMATION, REMOVAL (Specify) 1-4-72			24B. DATE 1-4-72		
24C. NAME of CEMETERY or CREMATORIA ANATOMY BOARD OF MARYLAND			24D. ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE		
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972			25B. NAME OF REGISTRAR Ruth E. Kelly, Jr.		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-240 71 12246		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12246	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JOHN W. NICOL</u>		2. DATE AND HOUR OF DEATH <u>12/19/71</u> <u>12:40 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Baltimore, Md.</u> B. COUNTY <u>14-01</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Long Green Nursing Home.</u> <u>Melrose &amp; Bellows Ave.</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>227 W. Lafayette Ave.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/22/87</u>	9. AGE (In years last birthday) <u>34</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Gen + Electric</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John W. Nicol</u>			14. MOTHER'S MAIDEN NAME <u>Unknown, Hasler</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-05-477</u>		17. INFORMANT <u>Wife - 227 W. Lafayette Ave.</u>	
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Heart disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized arteriosclerosis</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized arteriosclerosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>3 yr.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Jan 1955</u> to <u>12/19, 1971</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>12/15, 1971</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Norman R. Freeman</u>				23B. DATE SIGNED <u>12/19/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>NORMAN R. FREEMAN JR.</u>				23D. ADDRESS <u>11 W. 24th St Baltimore Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>12-20-71</u>		24B. DATE		24C. NAME OF CEMETERY <u>ANATOMY BOARD OF MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL</u>	
25D. ADDRESS <u>MORTUARY SERVICE - BCD</u>					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<b>S-352 71 12247</b> BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>71 12247</b>	
1. NAME OF DECEASED (Type or Print) <b>Margaret K. Stanis</b>			2. DATE AND HOUR OF DEATH <b>12/23/71 8:10 Pm.</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Montebello State Hospital.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland.</b> B. COUNTY <b>2744</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3113 Gibbons Ave</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/5/93</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taylor</b>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>			12. CITIZEN OF WHAT COUNTRY? <b>Lithuania.</b>		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215097602</b>		17. INFORMANT ADDRESS	
18. <b>183.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Ca of the ovary</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>July 1969</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Cesar L. Gonzalez C. MD</b>			23B. DATE SIGNED <b>12/23/71</b> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23C. PHYSICIAN'S NAME (Type) <b>Cesar L. Gonzalez C. MD</b>
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12-24-71</b>		24C. NAME OF CEMETERY or CREMATORIUM AND LOCATION <b>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</b> (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, MD</b>		25C. FUNERAL SERVICE - BOND <b>MORTUARY SERVICE - BOND</b>	



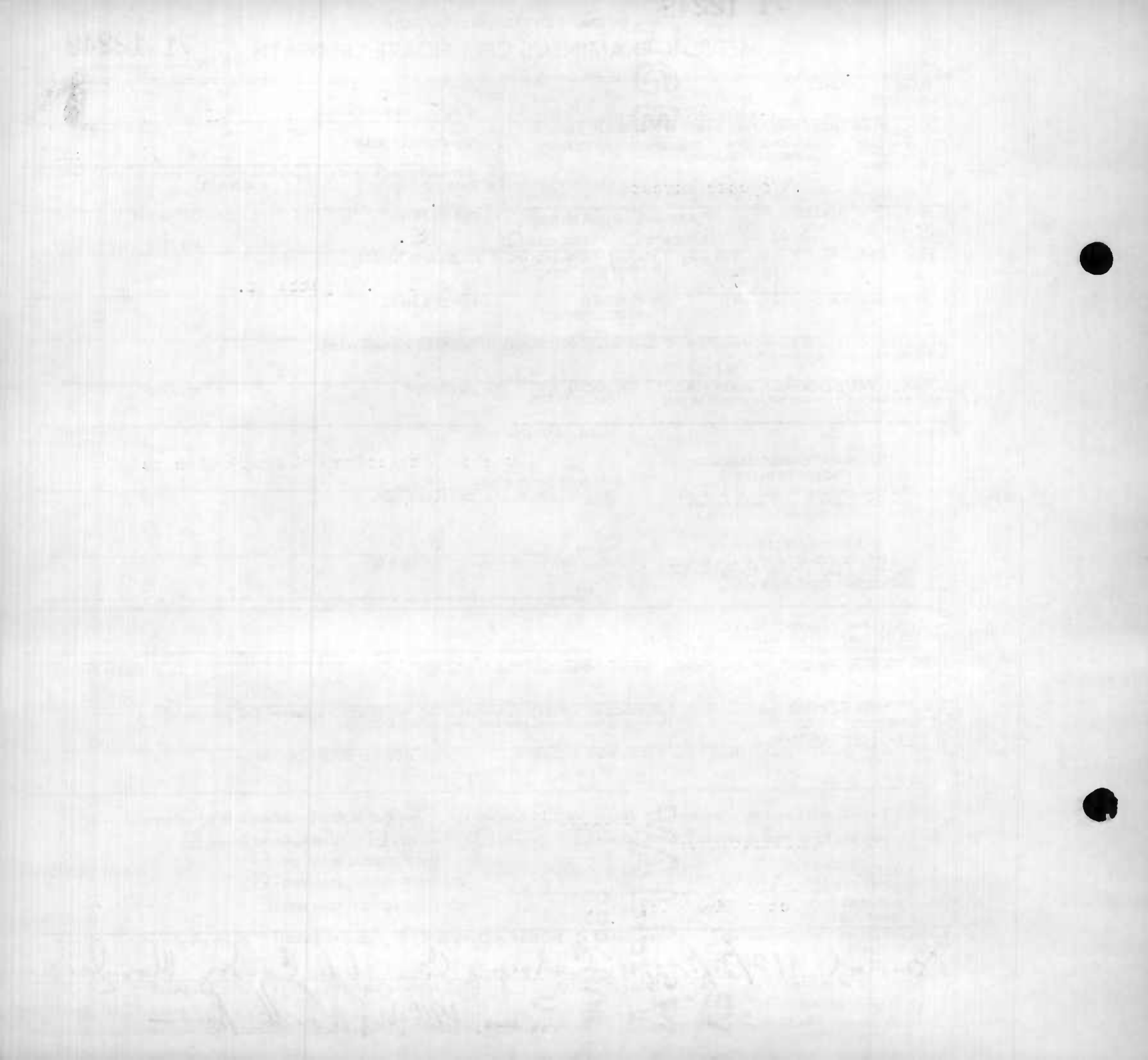
**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
L-200 71-33031 12248		CERTIFICATE OF DEATH		71 12248	
1. NAME OF DECEASED (Type or Print) <b>Law Boy "A" Gwendolyn</b>		2. DATE AND HOUR OF DEATH <b>12-23-1971 7 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. 21224</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2636</b>			
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>12/23/71</b> 9. AGE (in years lost birthday) <b>1 hour</b> If Under 1 Yr. Months: Days: <b>1</b> If Under 24 Hrs. Min. <b>1</b>	
13. FATHER'S NAME <b>Bernard</b>		14. MOTHER'S MAIDEN NAME <b>WATS, Gwendolyn</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records: BCH-4940 Eastern Ave. Dr SRABSTEIN BALT. CITY HOS</b>	
18. <b>175.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Heart failure</b> (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Anemia</b> <b>Hydrops Fetalis</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30'</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/23/71</b> 19 to <b>12/23/71</b> 19 that (I) (we) lost saw the deceased olive on <b>12/23</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Lighter</b>		23B. DATE SIGNED <b>12/23/71</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Srabstein</b> <b>Dr SRABSTEIN</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>12-27-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore City Hospitals</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>HOSPITAL DISPOSAL</b>	



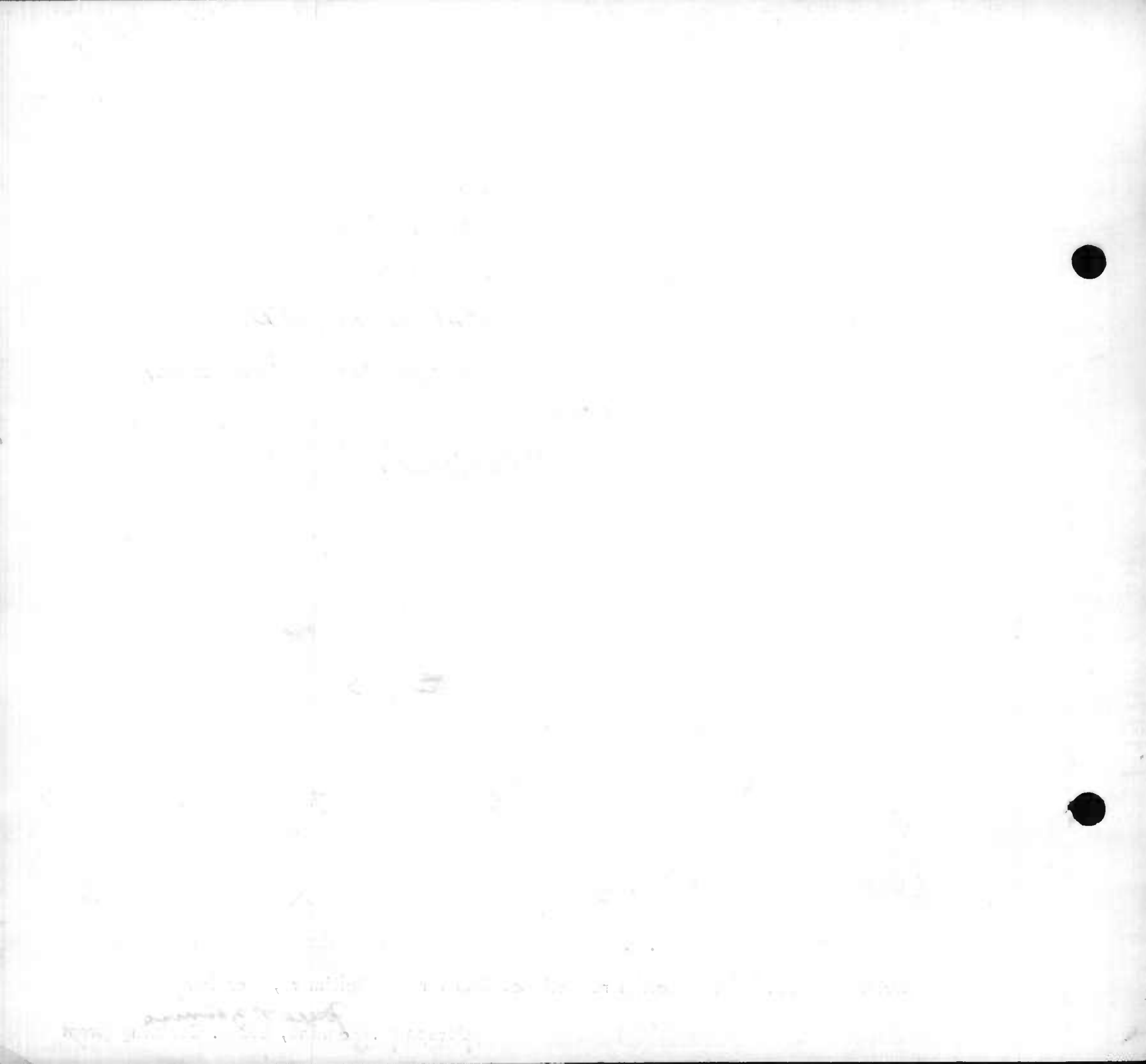
71 12249		BALTIMORE CITY HEALTH DEPARTMENT		71 12249	
7-652		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>	
		William Franklin		Month Day Year Hour 12 23 71 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 23 71 6:55 PM.		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Md. 1801	
00 829 W. Fayette Street					
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH	10. AGE (In years lost birthday) 74 74	11. BIRTHPLACE (State or foreign country)	E. STREET AND NUMBER 829 W. Fayette St.		
	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 519.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Chronic obstructive pulmonary disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type)  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED 12/24/71					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/30/71		Mt. Calver Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 5 1972		Robert E. Talley, M.D.		1912 W. North Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

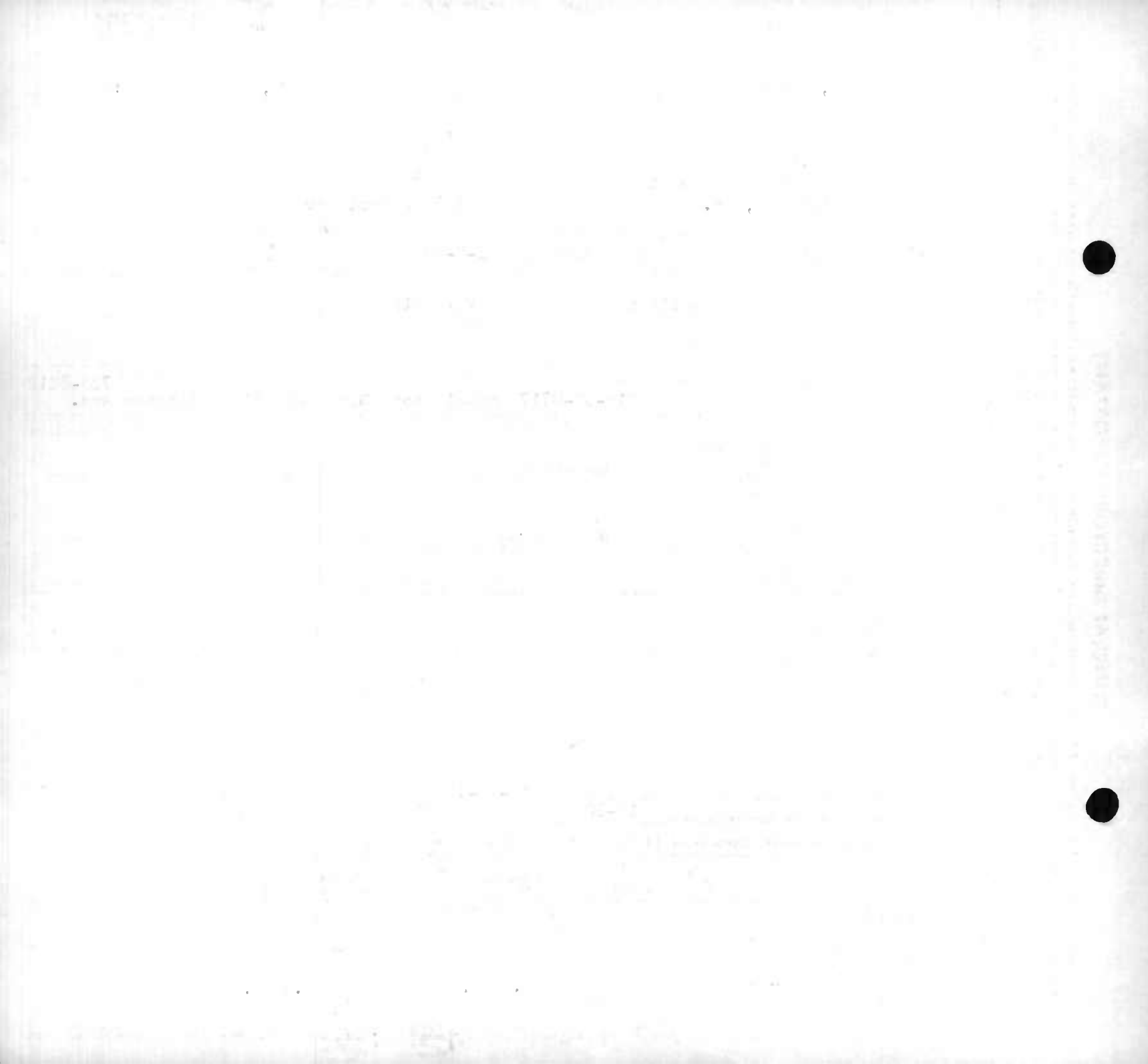
K-460 71 12250		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12250	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Kahler Ronald</i>		2. DATE AND HOUR OF DEATH <i>12-31-71</i> <i>2 AM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>2610</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>CHILDRENS HOSPITAL</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>247 S. Highland A</i>		8. DATE OF BIRTH <i>5-23-47</i>		9. AGE (in years lost birthday) <i>23</i>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>
11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Ernest</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Celozzi</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT ADDRESS	
18. <i>330.41</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <i>Upper Respiratory Infection</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>2d.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Muscular Dystrophy</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>23 yrs</i>	
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>NONE</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner <i>NONE</i> )		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>(H)</i> (this hospital) attended the deceased from <i>6-1-</i> 19 <i>70</i> to <i>12-31</i> 19 <i>71</i> that <i>(H)</i> (we) last saw the deceased alive on <i>12-31</i> 19 <i>71</i> and that in <i>(H)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(H)</i> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Arthur C. Burdett M.D.</i>		23B. DATE SIGNED <i>12-31-71</i>		23C. PHYSICIAN'S NAME (Type) <i>Arthur C. Burdett, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2x 1/4/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 5 1972</i>		25B. NAME OF REGISTRAR <i>Robert G. Jaberz</i>	
25C. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>		25D. ADDRESS <i>263 S. Conkling Street</i>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

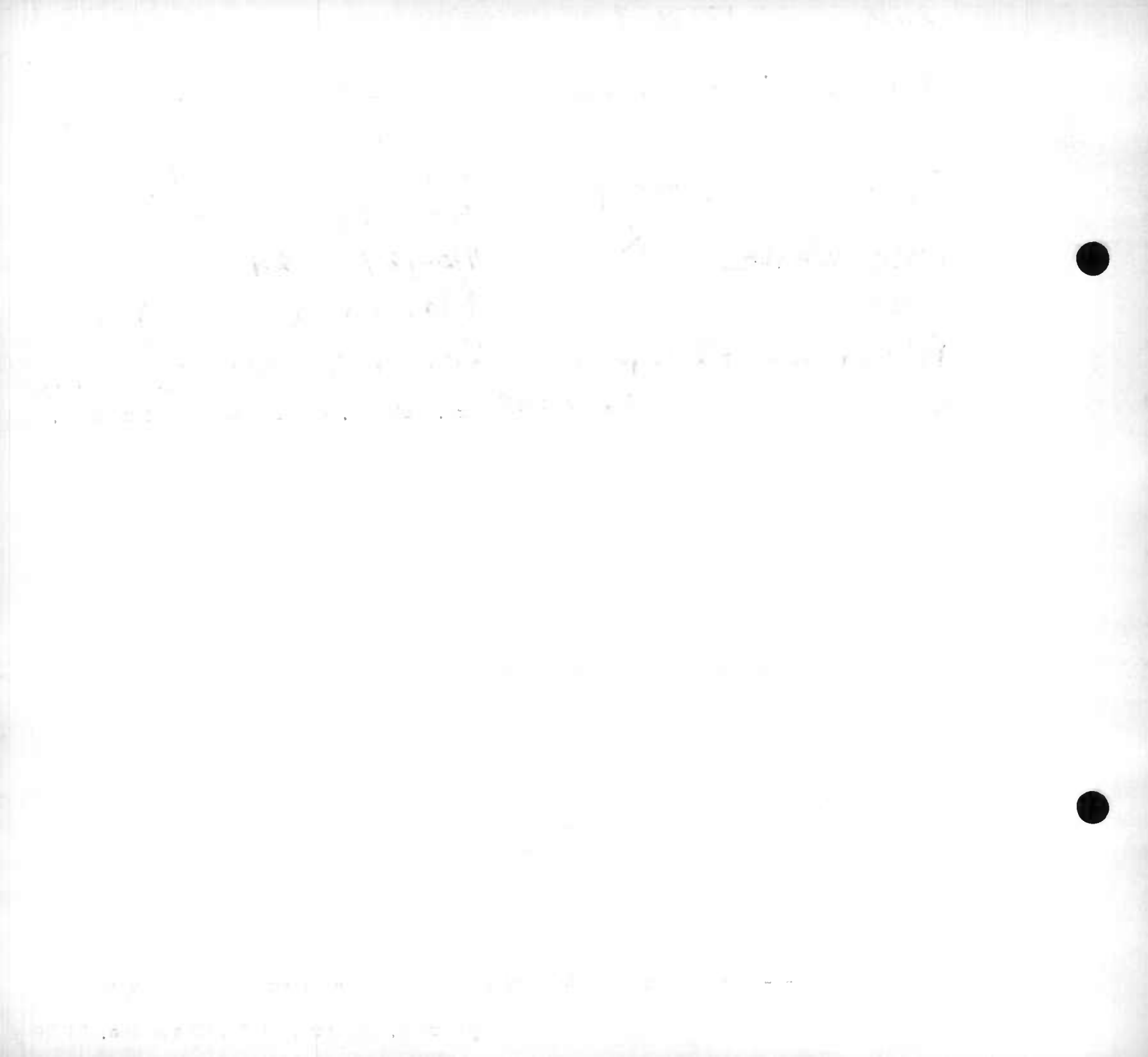
VS 150-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
P-412		71 12252		71 12252	
1. NAME OF DECEASED (Type or Print) <b>Mr. Isaac Phillipson</b>			2. DATE AND HOUR OF DEATH <b>Dec. 30, 1971 10. P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours Hosp.</b>			A. STATE <b>Maryland</b>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			B. COUNTY <b>2004</b>		
C. CITY OR TOWN <b>Baltimore</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>332 Tyrone St.</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/29/87</b>	9. AGE (In years last birthday) <b>84</b>	II Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Alexander Phillipson</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Herzog</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-18-0453</b>		17. INFORMANT <b>Mrs. Helen M. Phillipson, 332 Tyrone St.</b>	
18. <b>412.4.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cardio Pulmonary Arrest.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Atherosclerotic cardiovascular disease.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Rt. lower lobe Pneumonia.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (H) (this hospital) attended the deceased from <b>19</b> to <b>19</b> that (H) (we) last saw the deceased alive on <b>12/30</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Arvonne Bichairo Narongsonggram M.D.</b>				23B. DATE SIGNED <b>12/30/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>ARVORNEE BICHAIRO NARONGSONGRAM M.D.</b>				23D. ADDRESS <b>BON SECOURS HOSPITAL.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-4-1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery,</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 5 1972</b>			
25B. NAME OF REGISTRAR <b>Robert E. Hubbard</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			



1

R-100

71 12253

BALTIMORE CITY HEALTH DEPARTMENT

71 12253

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. NAME OF DECEASED (Type or Print) E. Lula Rapp		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 31 71 10:20 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 31 71 10:20 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10-4-1886		10. AGE (in years last birthday) 86 85	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Alfred Peaston		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Tody XXXXXXXX (Unknown)		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mr. John G. Rapp, 1110 W. Lombard St. 21223	
19. 4/2/4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. it means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)-			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u> DATE SIGNED 1-1-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-4-1972	
24C. NAME OF CEMETERY or CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-452 71 12254				BALTIMORE CITY HEALTH DEPARTMENT		71 12254	
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Collins, Harry L.</u>				2. DATE AND HOUR OF DEATH <u>12/31/71</u> <u>13</u> <u>A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL OF BALTIMORE</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD.</u>		B. COUNTY <u>BALTO.</u>	
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>912 Breezewick Rd #4</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/24/07</u>	9. AGE (In years last birthday) <u>64</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Controller</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. Country Club</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Collins</u>				14. MOTHER'S MAIDEN NAME <u>Alverta Shillings</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-10-8094</u>		17. INFORMANT <u>Mrs. Violet M. Collins</u>		ADDRESS	
18. <u>410.9 I</u> CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>2-3h</u>	
ANTECEDENT CAUSES				(B) <u>MYOCARDIAL Infarction</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>6 days</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <u>A.S.C.U.D</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>12/24</u> 19 <u>71</u> to <u>12/31</u> 19 <u>71</u> that (1) (we) lost saw the deceased alive on <u>12/31</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Leonardo E Vinuesa M.D.</u>						23B. DATE SIGNED <u>12/31/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Leonardo E Vinuesa</u>		DEGREE		23D. ADDRESS <u>SINAI Hospital of Balto.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Entombment</u>		24B. DATE <u>1/3/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Mas.</u>		24D. LOCATION (City, town or county) (State) <u>Balto.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Kelly</u>		25C. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home</u>		ADDRESS <u>6500 York Rd. 21212</u>	





71 12255		BALTIMORE CITY HEALTH DEPARTMENT		71 12255	
T-630				MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
BIRTH NO.		REG. NO.			
1. NAME OF DECEASED (Type or Print)		JOHN TRUITT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		University Hospital		3. DATE PRONOUNCED DEAD Month Day Year December 29, 1971 10:35 P.M.	
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH OCT. 2, 1948		10. AGE (In years last birthday) 23		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GORDON E. TRUITT		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY BALTIMORE 530	
15. MOTHER'S MAIDEN NAME M. ANGELA STAPLETON		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES APR. 1970 - DEC. 1970		17. SOCIAL SECURITY NO. 213-52-1964	
18. INFORMANT Joan F. Truitt - 7123 A Rolling Bend Rd.		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 11-30-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Head injuries		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Roland Road and Rte. #40	
22D. TIME OF INJURY (APPROX.) 11-30-71 12:15 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver in auto-auto collision	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> December 30, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-3-72		24C. NAME OF CEMETERY or CREMATORY Lafayette Cemetery	
24D. LOCATION (City, town, or county) (State) Crownsville, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR J. B. ...	
25C. FUNERAL DIRECTOR J. B. ...		ADDRESS Crownsville, Md.			

1-27-72 - Letter - Completion of cause of Death on a Pending Medical Examiner Death  
Certificate - Charles S. Springate, M.D.

HRS

7-651 71 12256 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 71 12256

BIRTH NO. REG. NO.

1. NAME OF DECEASED (Type or Print) Florence C. Frampton		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 31 Year 71 Hour 5:28 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 415 S. Bentalou Street		3. DATE PRONOUNCED DEAD Month 12 Day 31 Year 71 Hour 5:28 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Nov. 7-1916		10. AGE (In years last birthday) 55	
11. BIRTHPLACE (State or foreign country) Richmond Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin C. Sprull		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress	
15. MOTHER'S MAIDEN NAME Nellie Kaptore		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 225-12-1014		18. INFORMANT OTTIS FRAMPTON-415 S. BENTALOU ST	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Antecedent causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). fatty alteration of liver with pancreatitis and hemorrhage		20. DATE OF OPERATION	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? Ostend and Sharp Streets	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12 26 71 8:37 P. M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Auto accident		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL (REMOVAL) 1/3/72		24B. DATE 1/3/72	
24C. NAME OF CEMETERY or CREMATORY London Park Cem		24D. LOCATION (City, town, or county) (State) Frederick Ave. Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		25D. ADDRESS KRAUSIG FUN HOME 1216 S. CHARLES ST	

VS 151-REV. 1/1/68

WEST R. DRIVE 105 CLEVELAND ST. N. 18326

Richard Y. King + 2 + 2  
W. R. King + 2 + 2  
T. R. King + 2 + 2

11/17/72 - 11/17/72  
11/17/72 - 11/17/72

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 12257	
CERTIFICATE OF DEATH				REG. NO. 71 12257	
BIRTH NO. <u>H-145</u>		71 12257			
1. NAME OF DECEASED (Type or Print) <u>Margaret T. Haviland</u>		2. DATE AND HOUR OF DEATH <u>12-31, 1971</u> <u>10<sup>10</sup></u> <u>P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Gould Convalesarium</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>6116 Belair Rd.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>437 Evesham Ave</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, '95</u>	9. AGE (in years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
13. FATHER'S NAME <u>Patrick McGinity</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Dunnion</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 12 1195</u>		17. INFORMANT ADDRESS <u>Mr. Edward J. Haviland 515 W. Joppa Rd.</u>	
18. <u>412.3 I</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Chronic Congestive Heart Failure</u> <u>Chronic Brain Syndrome</u> <u>Osteoarthritis</u>		(C) _____			
19A. DATE OF OPERATION <u>12/31/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <u>1 Month</u> <u>1 Day</u> <u>1 Year</u> <u>1 Hour</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(the deceased)</u> attended the deceased from <u>11/5/1971</u> to <u>12/31/1971</u> that (I) <u>(we)</u> last saw the deceased alive on <u>12/31/1971</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Albert B. Bradley</u>		23B. DATE SIGNED <u>1/3/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Albert B. Bradley, M.D.</u>	
23D. ADDRESS <u>4900 Belair Road 21206</u>		23E. FUNERAL DIRECTOR ADDRESS <u>Mitchell Wiedefeld Home 6500 York Rd.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/4/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Reisterstown</u>		24E. LOCATION (City, town, or county) <u>Balto</u>		24F. LOCATION (City, town, or county) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>K-500 71 12258</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.5em;">71 12258</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Abraham Kahn</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">December 31/71 11:00 P.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">90 Edgewood Nursing Home Bulona + Belvedere Ave</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">BALTO</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">6652 Sango Road - Apt C</span>	
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">84</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Inspector</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">City of Balto</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Russia</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Wahraon Kahn</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Hannah ?</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO.	
17. INFORMANT <span style="font-size: 1.2em;">Mrs. Sarah Kahn - 6652 Sango Rd</span>		ADDRESS <span style="font-size: 1.2em;">Apt C</span>	
18. <span style="font-size: 1.2em;">412.4 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH <span style="font-size: 1.5em;">CVA</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">art rel CV + CNS</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <span style="font-size: 1.2em;">No</span> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">10 days</span> <span style="font-size: 1.2em;">2 yr</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <span style="font-size: 1.2em;">No</span> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">10/12</span> 19 <span style="font-size: 1.2em;">71</span> to <span style="font-size: 1.2em;">12/31</span> 19 <span style="font-size: 1.2em;">71</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12/31</span> 19 <span style="font-size: 1.2em;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">Maurice Feldman MD</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">1/1/72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">MAURICE FELDMAN</span>		23D. ADDRESS <span style="font-size: 1.2em;">6610 CROSS COUNTRY BLVD</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">Jan 2/72</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Beth Isaac Adath Israel</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, MD</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 5 1972</span>	25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. ...</span>	25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Sol ...</span>	ADDRESS <span style="font-size: 1.2em;">6610 Rustentown</span>





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12259

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH LYONS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour December 30, 1971 5:50 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY BALTO 5300		6. SEX Male 7. RACE White 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH NOVEMBER 4, 1927 10. AGE (in years last birthday) 44XX		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MAURICE LYONS	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		15. MOTHER'S MAIDEN NAME FANNIE HELLER	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES KOREAN WAR		17. SOCIAL SECURITY NO. 216-20-7138	
18. INFORMANT ADDRESS MRS. SELMA LYONS, 6804 WELLWOOD CT. #21209		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) American Meat Market	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1703 Guilford Avenue		22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) 12-30-71 5:25 P.M.	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during attempted robbery and assault	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/31/71	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-2-1972	
24C. NAME OF CEMETERY or CREMATORY LIBERTY PARK		24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD BALTIMORE, MARYLAND 21215			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

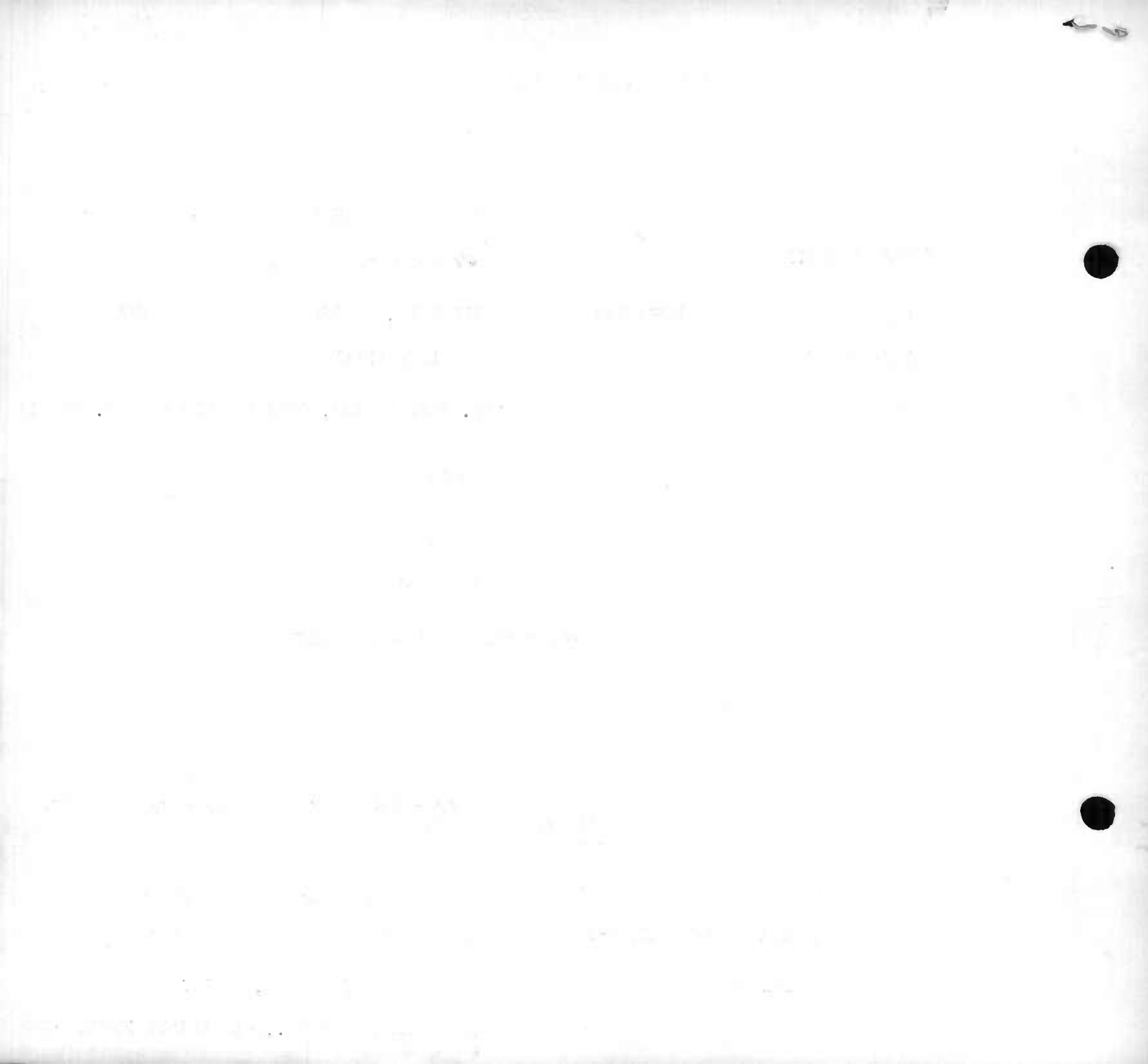
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 12260	
BIRTH NO. <u>M-260</u>		71 12260		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <u>LUCILLE MAZER</u>		2. DATE AND HOUR OF DEATH <u>12/31/71</u> <u>8<sup>25</sup> P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>BALTO</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>42</u>		E. STREET AND NUMBER <u>11 SWAN HILL DRIVE</u>			
5. SEX <u>F</u>	6. RACE <u>CAUC.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/6/26</u>	9. AGE (In years last birthday) <u>45</u>	10. Under 1 Mo. <input type="checkbox"/> 1 To 12 Hrs. <input type="checkbox"/> 12 Hrs. <input type="checkbox"/> 24 Hrs. <input type="checkbox"/> Min. <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Atlantic City, N.J.</u>	
13. FATHER'S NAME <u>Nathan Muttlerman</u>		14. MOTHER'S MAIDEN NAME <u>Sarah</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Bernard Mazer - Same</u>	
18. <u>430.9 I</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<u>SUBARACHNOID HEMORRHAGE</u>		<u>1 WEEK</u>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		<u>POSTERIOR COMMUNICATING ARTERY ANEURYSM</u>		<u>2 YEARS</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>12/30/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CEREBRAL ANEURYSM</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/17/71</u> to <u>12/31/71</u> that (I) (we) last saw the deceased alive on <u>12/31/71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Israel Weiner M.D.</u>				23B. DATE SIGNED <u>12/31/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ISRAEL WEINER, M.D.</u>		23D. ADDRESS <u>Sinai Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1/2/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Chet Shalom</u>	
24D. LOCATION (City, town, or county) <u>Baltimore (Reisterstown)</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jolly, No. 1000</u>		25C. FUNERAL DIRECTOR <u>Robert E. Jolly</u>			
25D. ADDRESS <u>6000 Reisterstown Rd.</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

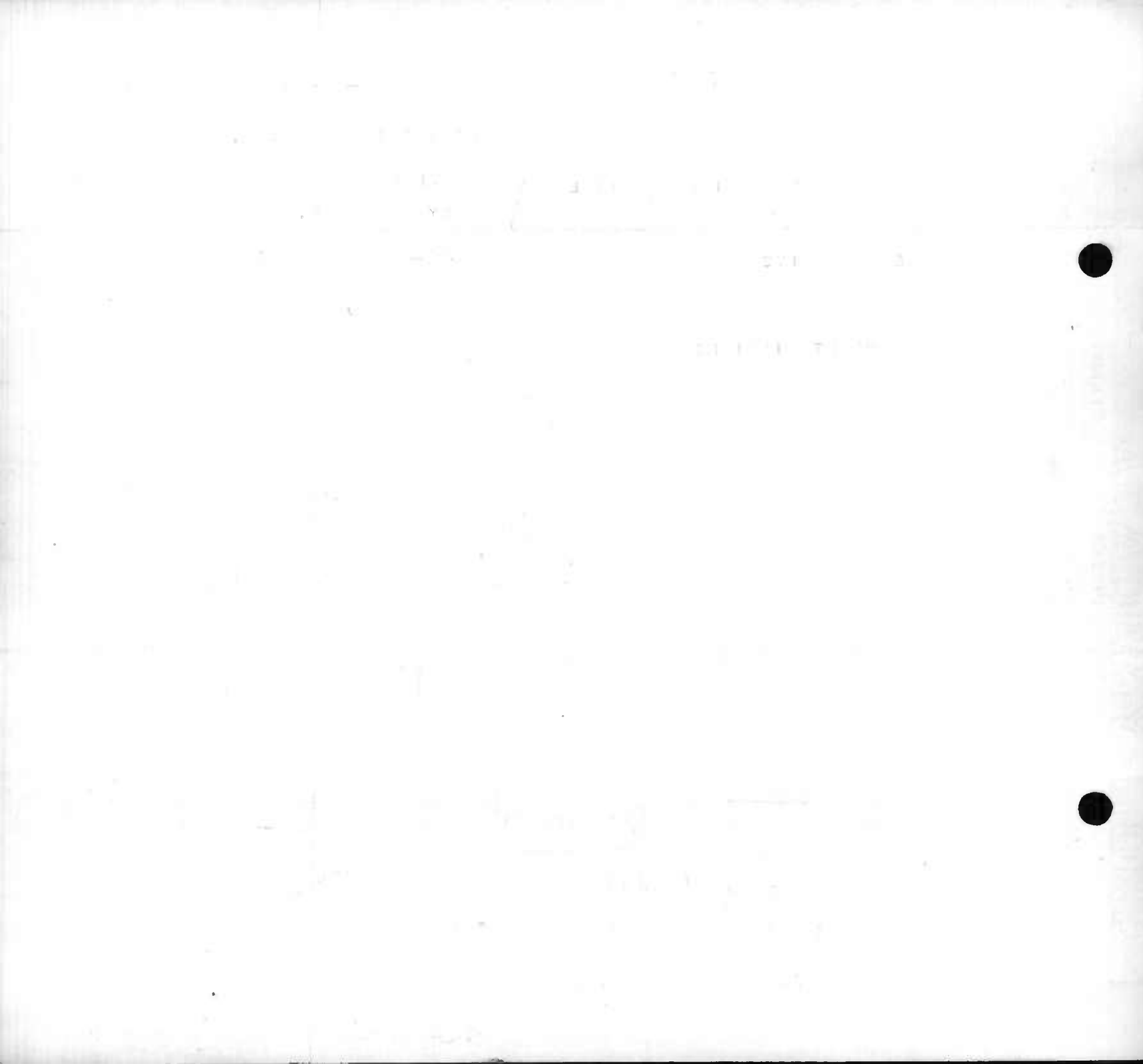
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12261</u>	
C-145 <u>71 12261</u>				CERTIFICATE OF DEATH	
BIRTH NO. <u>71 12261</u>		1. NAME OF DECEASED (Type or Print) <u>GILBERT CAPLAN</u>		2. DATE AND HOUR OF DEATH <u>12-31-71</u> <u>7:10 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2831</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>6964 GLENHEIGHTS RD. #15</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>09-26-1903</u>	9. AGE (in years last birthday) <u>68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AGENT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>		11. BIRTHPLACE (State or foreign country) <u>LIVERPOOL, ENGLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>HYMAN CAPLAN</u>			14. MOTHER'S MAIDEN NAME <u>LEAH KELLY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. ROSE CAPLAN, 6964 GLENHEIGHTS RD. #21215</u>	
18. <u>4124 I</u> CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>(A) IMMEDIATE CAUSE PNEUMONIA</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u>  <u>(B) CHF</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u>  <u>(C) ASCVD</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>RENAL FAILURE</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-03</u> 19 <u>71</u> to <u>12-31</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12-31</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Peter Oroszlan</u> <u>MD</u> DEGREE				23B. DATE SIGNED <u>12-31-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>PETER OROSZLAN</u>				23D. ADDRESS <u>3 HAMILL RD APT 5.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-2-1972</u>		24C. NAME of CEMETERY or CREMATORY <u>MIKRO KODESH</u>	
				24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		25B. NAME OF REGISTRAR <u>J. E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		71 12262	
W-452		71 12262	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
HUBERT WILLIAMS		12-31-71 2:00 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
THE JOHNS HOPKINS HOSPITAL		MARYLAND A. A. CO	
33		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
		BALTIMORE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER	
		HOLY CROSS RD. 318	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11-30-12
9. AGE (in years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
59		Plumber	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Cass West Va.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
HUBERT WILLIAMS		Cora Dixon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		233 10 3477	
17. INFORMANT		ADDRESS	
Mary Williams		318 Holy Cross Road 21225	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		yes	no
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from December 29 1971 to December 31 1971 that (I) (we) last saw the deceased alive on December 31 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Ronald J. Innerfield, M.D.			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Ronald J. Innerfield, M.D.		6004 EAST PRATT STREET, Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/4/72	Glen Haven Cemetery	Glen Burnie Md.
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 5 1972	Valerie E. Valerius, R.D.	14245	Federal Home 237 atapsco Ave 21225





# FUNERAL DIRECTOR: IMPORTANT

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S-625		71 12263		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12263	
1. NAME OF DECEASED (Type or Print) <b>SCROGGINS, FULTON</b>				2. DATE AND HOUR OF DEATH <b>December 30, 1971 6:40 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>VETERANS ADMINISTRATION HOSPITAL</b> <b>3900 Loch Raven Blvd</b> <b>Baltimore, Maryland 21218</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1605</b>			
5. SEX <b>MALE</b>		6. RACE <b>NEGROID</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/29/13</b>	
9. AGE (In years last birthday) <b>58</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MOSSON SCRUGGINS</b>				14. MOTHER'S MAIDEN NAME <b>EDNA HENSON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>218 10 3005</b>		17. INFORMANT ADDRESS <b>CLIN RCDS, VAH, BALTIMORE, MARYLAND</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL DAMAGE</b> <b>LIVER AND RENAL FAILURE</b>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION <b>12/27/71</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>1</b> 19C. AUTOPSY? (Yes or No) <b>YES</b> 20A. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <input type="checkbox"/>			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from <b>December 28, 1971</b> to <b>December 30, 1971</b> , that (X) (we) lost saw the deceased alive on <b>December 30, 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.							
23A. SIGNATURE <i>Lawrence Mills</i>				23B. DATE SIGNED <b>12/31/71</b>		23C. PHYSICIAN'S NAME (Type) <b>LAWRENCE MILLS, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. NAME OF CEMETERY or CREMATORY <b>1-4-72 ARBUTUS MEM PARK</b>		24C. LOCATION (City, town, or county) (State) <b>ARBUTUS, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1972</b>				25B. NAME OF REGISTRAR <i>Robert E. Miller, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Ed. O. Wilson 1000 BRANTLEY AVE</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 12264</u>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>LOUIS EDGAR MARTINDALE</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>December 31, 1971</u>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <u>40 St. Agnes Hospital</u> <u>Wilkins &amp; Caton Avenues</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) <b>A. STATE</b> <u>Maryland</u> <b>B. COUNTY</b> <u>2582</u> <b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>2808 Washington Blvd.</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1-12-1897</u>	<b>9. AGE</b> (In years last birthday) <u>74</u>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Police</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Police</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Baltimore City</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>Frank Martindale</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Lena Weisman</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes W W I</u>		<b>16. SOCIAL SECURITY NO.</b> <u>212-46-9746</u>		<b>17. INFORMANT</b> <u>Mr. Marvin E. Martindale, 1206 Canberwell Rd.</u>	
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>410.4 I</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <u>Sudden death - massive myocardial infarction</u> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) <u>A.S. Heart disease</u></b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b>			
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <u>1970</u> to <u>12.31</u> 1971</b> <b>that (I) (we) last saw the deceased alive on <u>12.31</u> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Stanley Ankudas</u>				<b>23B. DATE SIGNED</b> <u>1.3.72</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Stanley Ankudas</u>				<b>23D. ADDRESS</b> <u>1101 Maiden Choice Lane, Balto., Md. 21229</u>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>24B. DATE</b> <u>1-4-1972</u>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cemetery</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 7 1972</u>			
<b>25B. NAME OF REGISTRAR</b> <u>Howard H. Hubbard</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Howard H. Hubbard, 4107 Wilkins Ave. 21229</u>			

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

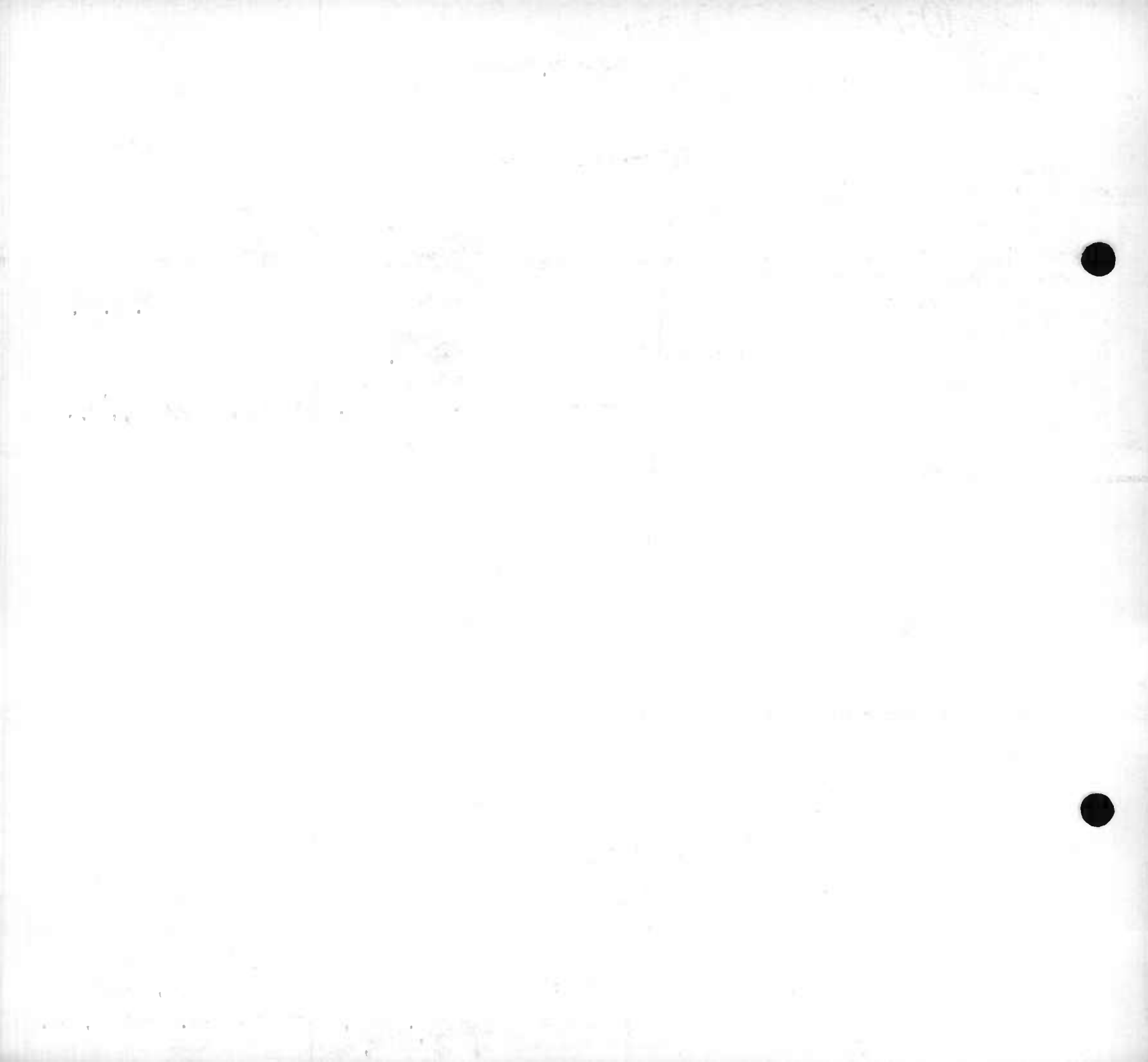
1. NAME OF DECEASED (Type or Print) John B. Sheffield		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 31 71 4:14 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		3. DATE OF PRONOUNCED DEAD Month Day Year Hour 12 31 71 4:14 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Carroll		6. CITY OR TOWN Sykesville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 2-7-1932	10. AGE (In years last birthday) 39	E. STREET AND NUMBER 509A - Klee Mill Road	
11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME John J. Sheffield	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		14B. KIND OF BUSINESS OR INDUSTRY Food Fair Co.	
15. MOTHER'S MAIDEN NAME Clarice V. Merrell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mrs. Joan Ann Sheffield, 1833 Frederick Ave. 21223	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 9681X Multiple traumatic injuries DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 12/31/71 A.M. Unknown		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street 22C. WHERE DID INJURY OCCUR? Found - Rear of 1700 E. 25th St.	
22D. TIME OF INJURY (APPROX.) 12/31/71 A.M. Unknown		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 22F. HOW DID INJURY OCCUR? Unknown Run over by truck	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-2-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-1972	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR Robert E. Huber, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.		25D. ADDRESS 21229	

1-13-72 - Letter from - Office of the Chief Medical Examiner, Ronald N. Kornblum, M.D.  
Assistant Medical Examiner

HRS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12266</b>	
71 12266 CERTIFICATE OF DEATH					
BIRTH NO. <b>W-656</b>		1. NAME OF DECEASED (Type or Print) <b>Warner Sarah</b>		2. DATE AND HOUR OF DEATH <b>12/31/71 5:50 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Johns Hopkins Hosp.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>302</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Johns Hopkins Hosp.</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>Female</b>			6. RACE <b>Cauc.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>2/2/90</b>			9. AGE (In years last birthday) <b>81</b>		10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Edward Brownawelle</b>		
14. MOTHER'S MAIDEN NAME <b>Mary E. Horne</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>212-20-5759T</b>			17. INFORMANT (Daughter) <b>1217 Travers Way, Mrs. Frances L. Griffith, Baltimore, Md.</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Shock</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypovolemia + Heart Failure</b> <b>Possible SMA infarct</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II Atrial Fibrillation</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>12/30/71</b> to <b>12/31/71</b> and that (2) (we) last saw the deceased alive on <b>12/31/71</b> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.)					
23A. SIGNATURE <b>George W. Taylor MD</b>				23B. DATE SIGNED <b>12/31/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>George W. Taylor MD</b>				23D. ADDRESS <b>Johns Hopkins Hosp. Baltimore Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/3/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>			
25B. NAME OF REGISTRAR <b>John J. Duda</b>		25C. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>			

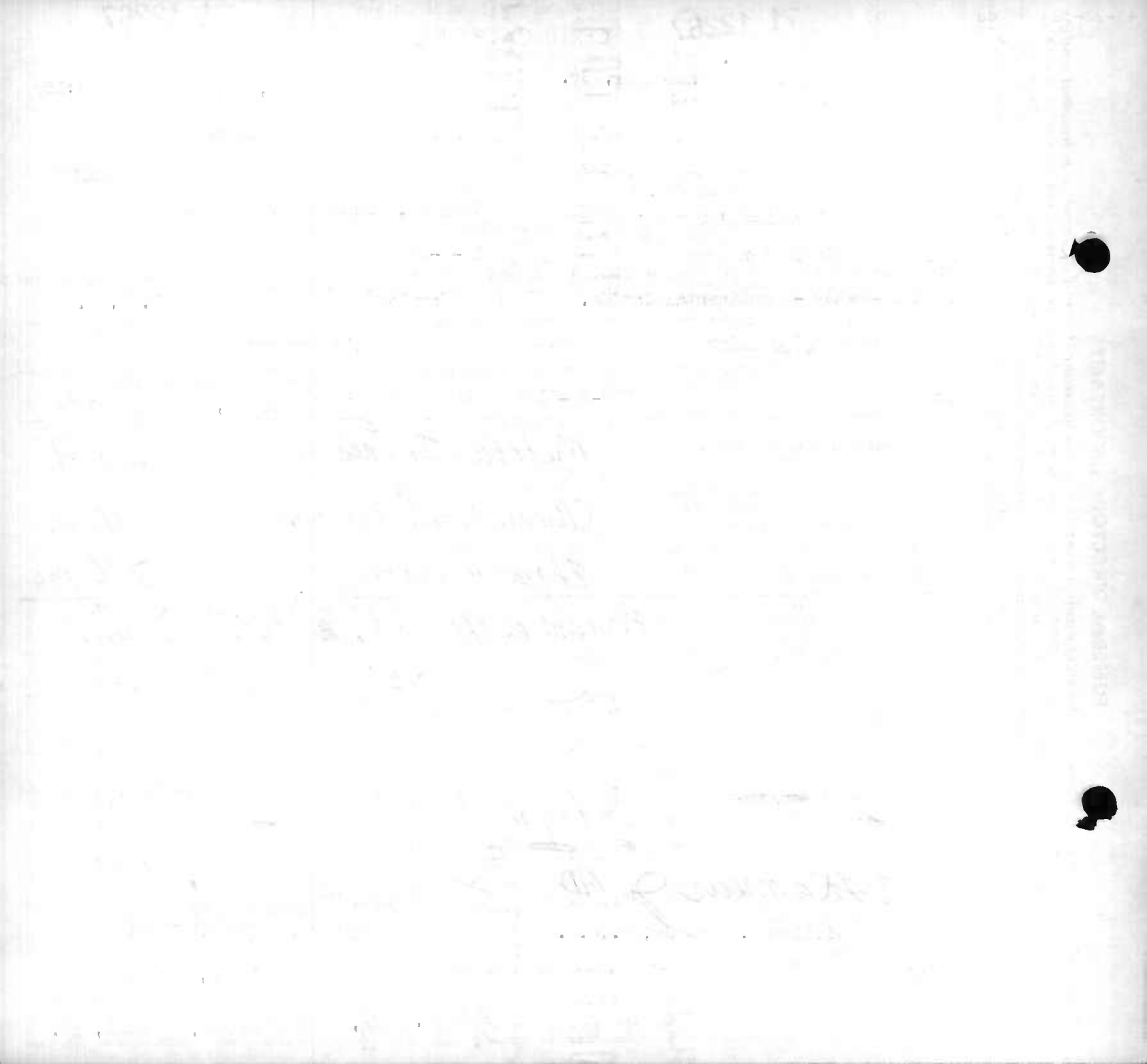




## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>R-521</i>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <i>71 12267</i>			
1. NAME OF DECEASED (Type or Print) <i>J. Francis Reinsfelder, Sr.</i>				2. DATE AND HOUR OF DEATH <i>December 31, 1971 1:15p.m.</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>Baltimore</i>		<i>5300</i>			
5. SEX <i>Male</i>		6. RACE <i>Caucasian</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-8-26</i>		9. AGE (in years last birthday) <i>45</i>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lift Operator - Continental Can Co.</i>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Reinsfelder</i>				14. MOTHER'S MAIDEN NAME <i>Elsie Connors</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>219-20-8143</i>		17. INFORMANT <i>BCH RECORDS: 4940 Eastern Avenue Baltimore, Maryland 21224</i>				ADDRESS	
18. <i>582X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Metabolic Imbalance</i>				CAUSE OF DEATH <i>Metabolic Imbalance</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>~ 1 wk.</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Renal Failure</i>				<i>10 mo.</i>			
				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertension</i>				<i>&gt; 10 mo.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Pericardial Effusion, Chronic Hypotension, R.D. hemiparesis</i>											
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) <del>(the physician)</del> attended the deceased from <i>12/21/71</i> 19 to <i>12/31/71</i> 19 that (I) <del>(we)</del> last saw the deceased alive on <i>12/31/71</i> 19 and that in (my) <del>(our)</del> opinion death occurred on the date and hour end from the causes stated above. (I) <del>(we)</del> (did) <del>(not)</del> view the body after death.											
23A. SIGNATURE <i>W. L. Ramseur Jr. MD</i>								23B. DATE SIGNED <i>12/31/71</i>			
23C. PHYSICIAN'S NAME (Type) <i>William L. Ramseur, Jr., M.D.</i>				23D. ADDRESS <i>4940 Eastern Avenue Baltimore, Maryland 21224</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/4/72</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>		24D. LOCATION <i>Baltimore, Maryland</i>		24E. LOCATION <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 7 1972</i>		25B. NAME OF REGISTRAR <i>John J. Duda, Jr.</i>		25C. FUNERAL DIRECTOR <i>John J. Duda, Jr.</i>		ADDRESS <i>7922 Wise Ave. Dundalk, Md.</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BIRTH NO.</b> <span style="font-size: 1.5em;">M-416</span> <span style="font-size: 1.5em;">71 12268</span></p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b></p>		<p><b>REG. NO.</b> <span style="font-size: 1.5em;">71 12268</span></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">MILBOURNE RONALD J.</span></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">12-30-71</span> <span style="font-size: 1.2em;">19:58</span> P.M.</p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">JOHNS HOPKINS HOSPITAL</span></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">Somerset</span></p> <p><b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">CRISFIELD</span> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p><b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">227 MAIN ST.</span></p>	
<p><b>5. SEX</b> <span style="font-size: 1.2em;">Male</span></p>	<p><b>6. RACE</b> <span style="font-size: 1.2em;">Caucasian</span></p>	<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">June 14, 1906</span></p>
<p><b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">65</span></p>		<p><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Seaford Worker - Labor</span></p>	
<p><b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Crisfield, Md.</span></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span></p>	
<p><b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Romey Milbourne</span></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Grace M. Milbourne</span></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span></p>	<p><b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">213-10-8039</span></p>	<p><b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mrs. Ruby Milbourne, Same as 4.</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">abcde</span></p>	
<p><b>18. CAUSE OF DEATH</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">(A) IMMEDIATE CAUSE <u>ASCITES</u> DUE TO, OR AS A CONSEQUENCE OF:</span></p> <p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">(B) <u>LIVER DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF:</span> <span style="font-size: 1.2em;">(C) <u>Unknown</u></span></p>			<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">few wks.</span>  <span style="font-size: 1.2em;">Unknown</span></p>
<p><b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">NONE</span></p>	<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	<p><b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">Yes</span></p>	<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <span style="font-size: 1.2em;">No</span></p>
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>	<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>	<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (1) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12-27-</span> <span style="font-size: 1.2em;">1971</span> to <span style="font-size: 1.2em;">12-30</span> <span style="font-size: 1.2em;">1971</span> that (2) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">12-30-</span> <span style="font-size: 1.2em;">1971</span> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) <del>not</del> view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Kenneth A. Krackow, MD</span></p>		<p><b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/></p>	<p><b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">12-30-71</span></p>
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">KENNETH A. KRACKOW</span></p>		<p><b>23D. ADDRESS</b> <span style="font-size: 1.2em;">JOHNS HOPKINS HOSPITAL</span></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span></p>	<p><b>24B. DATE</b> <span style="font-size: 1.2em;">1/3/72</span></p>	<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Sunnyridge Cemetery</span></p>	<p><b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Crisfield, Somerset, Md.</span></p>
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JAN 7 1972</span></p>		<p><b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">[Signature]</span></p>	<p><b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Bradshaw &amp; Sons, Crisfield, Md. 21817</span> <b>ADDRESS</b></p>

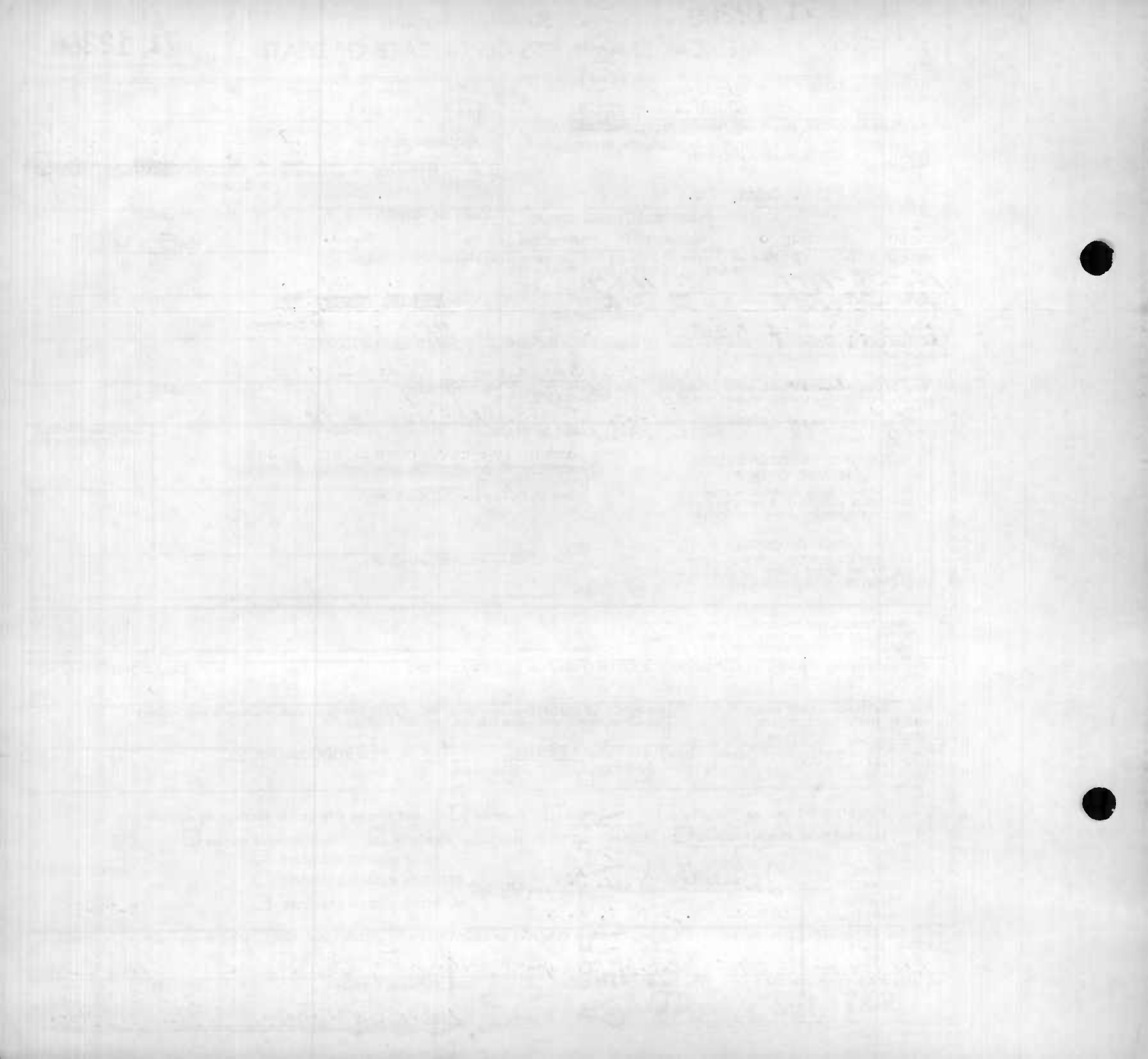


W-300 71 12269 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 71 12269

BIRTH NO. REG. NO.

1. NAME OF DECEASED (Type or Print) <b>JOHNNY JOHNIE L. WHITE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>641 N. Carey St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 27 1971 10:10a</b> M.	
6. SEX <b>male</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>negro</b>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>12-30-1917</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) <b>53</b>		E. STREET AND NUMBER <b>641 N. Carey St.</b>	
11. BIRTHPLACE (State or foreign country) <b>High Point N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alex White</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction</b>	
15. MOTHER'S MAIDEN NAME <b>Jessie Lawson</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes 7-14-45 to 10-18-45</b>	
17. SOCIAL SECURITY NO. <b>43-10-9031</b>		18. INFORMANT <b>Malvin Klukas</b>	
19. <b>4-12-21</b>		CAUSE OF DEATH <b>Hypertensive cardiovascular disease</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>no</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>12-27-71</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-4-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Arburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Bullock's Mortuary</b>		ADDRESS <b>712-14 E. North Ave</b>	

VS 151-REV. 1/1/68



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print)		Kenneth C. Lancaster		2. DATE OF DEATH		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month		Day		Year		Hour									
								12		31		71		4:54 P. M.									
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				3. DATE PRONOUNCED DEAD				Month				Day				Year				Hour			
FULL NAME OF HOSPITAL OR INSTITUTION				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				12				31				71				4:54 P. M.			
31				Baltimore City Hospitals				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				A. STATE				B. COUNTY							
								Maryland				2544											
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?															
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
9. DATE OF BIRTH				10. AGE (In years last birthday)				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME							
3/31/41				30				Maryland				U.S.				Vernon W. Lancaster							
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY				15. MOTHER'S MAIDEN NAME															
Plumber				Plumbing				Frances Duvree															
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.				18. INFORMANT				ADDRESS											
No				217 40 3797				Marva Anne Lancaster (same)															
19. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE				Multiple injuries															
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:																			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:																			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(C)																			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).																							
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No)															
2								Yes															
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?															
				Street				Tunnel freeway - 150' N. of Poncabird Pass															
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED				22F. HOW DID INJURY OCCUR?															
12 31 71 4:17 P.m.				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Driver of auto into bridge abutment															
23.																							
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion																							
resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED															
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																			
Werner U. Spitz, M.D.				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>												1-2-72							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)											
Burial				1/4/72				Cedar Hill Cemetery				Ritchie Hwy., A.A.Co., Md.											
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR				ADDRESS											
JAN 7 1972				George J. Gonce				George J. Gonce, 4001 Ritchie Hwy.,				Baltimore											

0:59:13

0:58:13

Victor W. Anderson

James W. Anderson

W. J. Anderson (son of James W. Anderson)

W. J. Anderson

W. J. Anderson

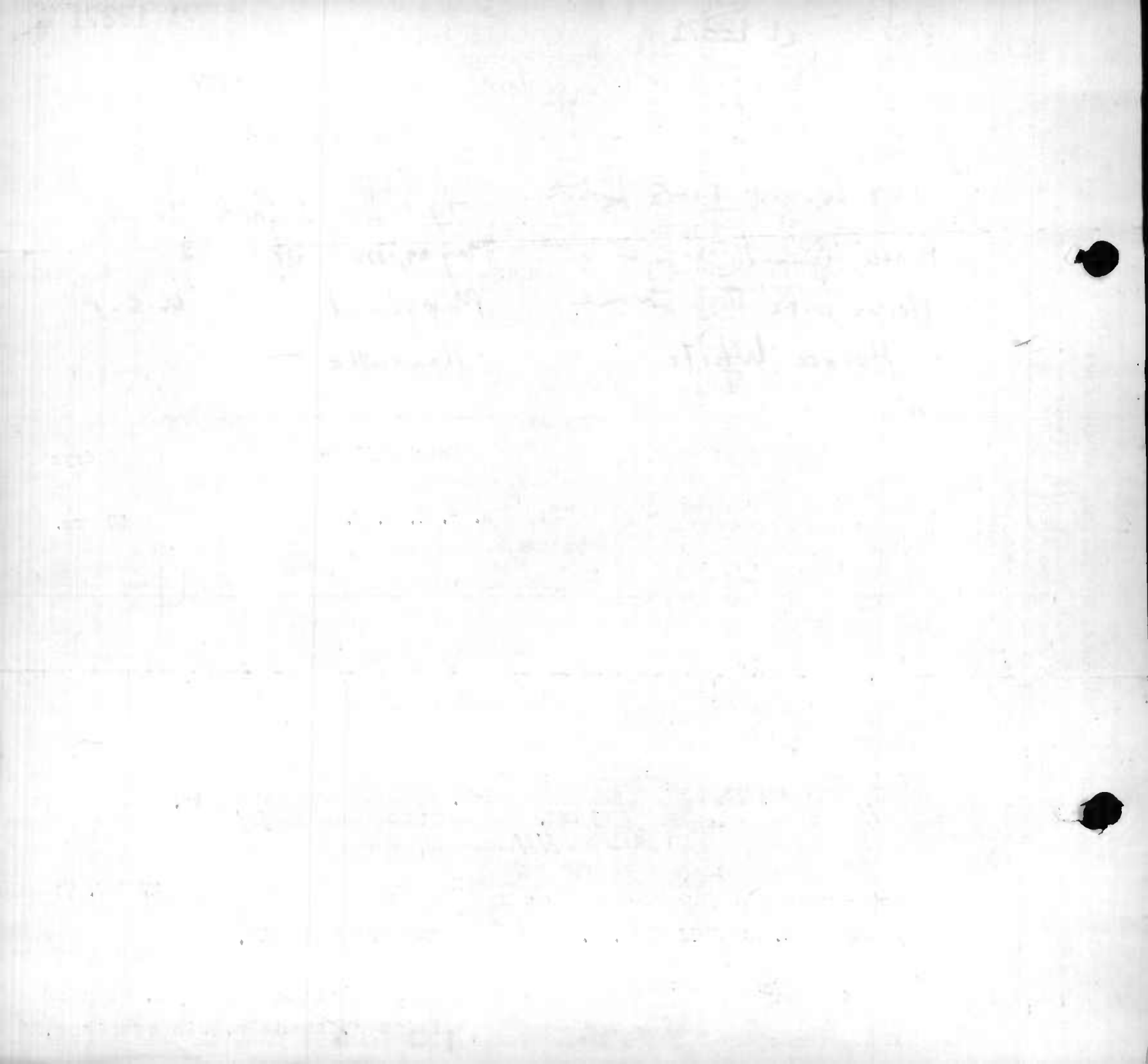
W. J. Anderson



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 12271</b>	
Q-535 71 12271				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Virginia Quinton		Dec. 23, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
727 Druid Park Drive			Maryland 1361		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			727 Druid Park Drive		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	Colored	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 29, 1880	91	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
House wife		none		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Hornace White			Hewitt -		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No					ADDRESS
18. <b>4124 I</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			Heart Failure		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			A. S. C. V. D.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
18. <b>4124 I</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			2 days		
			20 yrs.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the physician) attended the deceased from <b>Feb.</b> 1971 to <b>Dec.</b> 1971, that (I) <b>last</b> saw the deceased alive on <b>23 DEC.</b> 1971 and that in (my) <b>100%</b> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<b>Joshua R. Mitchell III MD</b>				27 DEC. 71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JOSHUA R. MITCHELL III .MD.				2202 GARRISON BLVD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/28/70		Gracexxxx Grace	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 7 1972		Robert E. Jones, Jr.		William H. James Jr. Princess Anne, Md	
				ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-200		71 12272		BALTIMORE CITY HEALTH DEPARTMENT SUGGS, PHILLIP N. 57 X 71 3 12272	
BIRTH NO.		71 12272		REG. NO.	
1. NAME OF DECEASED (Type or Print)		Phillip N. Suggs		DR. APPL. DATE AND HOUR OF DEATH 31 Dec 1971 2:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY M.D. Prince Georges 6600		C. CITY OR TOWN Chelfenham	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER P.O. Box 103 Boys Village	
5. SEX M	6. RACE BLACK	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-14	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Youth Supervisor Boys Village		10B. KIND OF BUSINESS OR INDUSTRY Boys Village		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Suggs		14. MOTHER'S MAIDEN NAME Sula	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic Renal Failure Cirrhosis of Liver Hepatic Failure Compression Fr. of C3-C4		CAUSE OF DEATH IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Quasoplegia [Cervical Spondylosis]		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/29/71 7/24/71	
19. DATE OF OPERATION 1/29/71		19A. CONDITION FOR WHICH OPERATION WAS PERFORMED Fr of C3-C4		20A. AUTOPSY (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME OF INJURY (APPROX.) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None	
22. I certify that (1) (this hospital) attended the deceased from 11-10-71 19 to 12-31-71 19 that (2) (we) last saw the deceased alive on 12-31-71 19 and that (3) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Jerome Koepfel, M.D.		23B. DATE SIGNED 31 Dec 1971		23C. PHYSICIAN'S NAME (Type) Jerome Koepfel, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) 1-8-72		24B. DATE 1-3-72		24C. NAME OF CEMETERY OR CREMATORY Lincoln	
24D. LOCATION Switzland, Md		25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR [Signature]		25D. ADDRESS 389 RF, sec nw, Wash. D.C.		25E. [Signature]	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-162		71 12273		BALTIMORE CITY HEALTH DEPARTMENT		71 12273	
BIRTH NO.		71 12273		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>JEFFERSON, William E.</b>				2. DATE AND HOUR OF DEATH <b>12/31/71 4:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Johns Hopkins Hospital</b>				A. STATE <b>Maryland</b>		B. COUNTY <b>908</b>	
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1224 E. North Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/16/12</b>	9. AGE (in years last birthday) <b>59</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Floyd Jefferson</b>			14. MOTHER'S MAIDEN NAME <b>Mary</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>234-36-1201</b>		17. INFORMANT ADDRESS <b>Margaret Jefferson 1224 E North</b>		
18. CAUSE OF DEATH <b>430.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Hepatic Failure</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Subarachnoid Hemorrhage</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>12/28</b> 19 <b>71</b> to <b>12/31</b> 19 <b>71</b> that (1) (we) last saw the deceased alive on <b>12/31</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Richard L. Taw Jr MD</b>				23B. DATE SIGNED <b>12/31/71</b>		23C. PHYSICIAN'S NAME (Type) <b>Richard L. Taw, M.D.</b>	
23D. ADDRESS <b>The Johns Hopkins Hospital</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-10-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>		25B. NAME OF REGISTRAR <b>Wm C March</b>		25C. FUNERAL DIRECTOR ADDRESS <b>928 E. North Ave.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

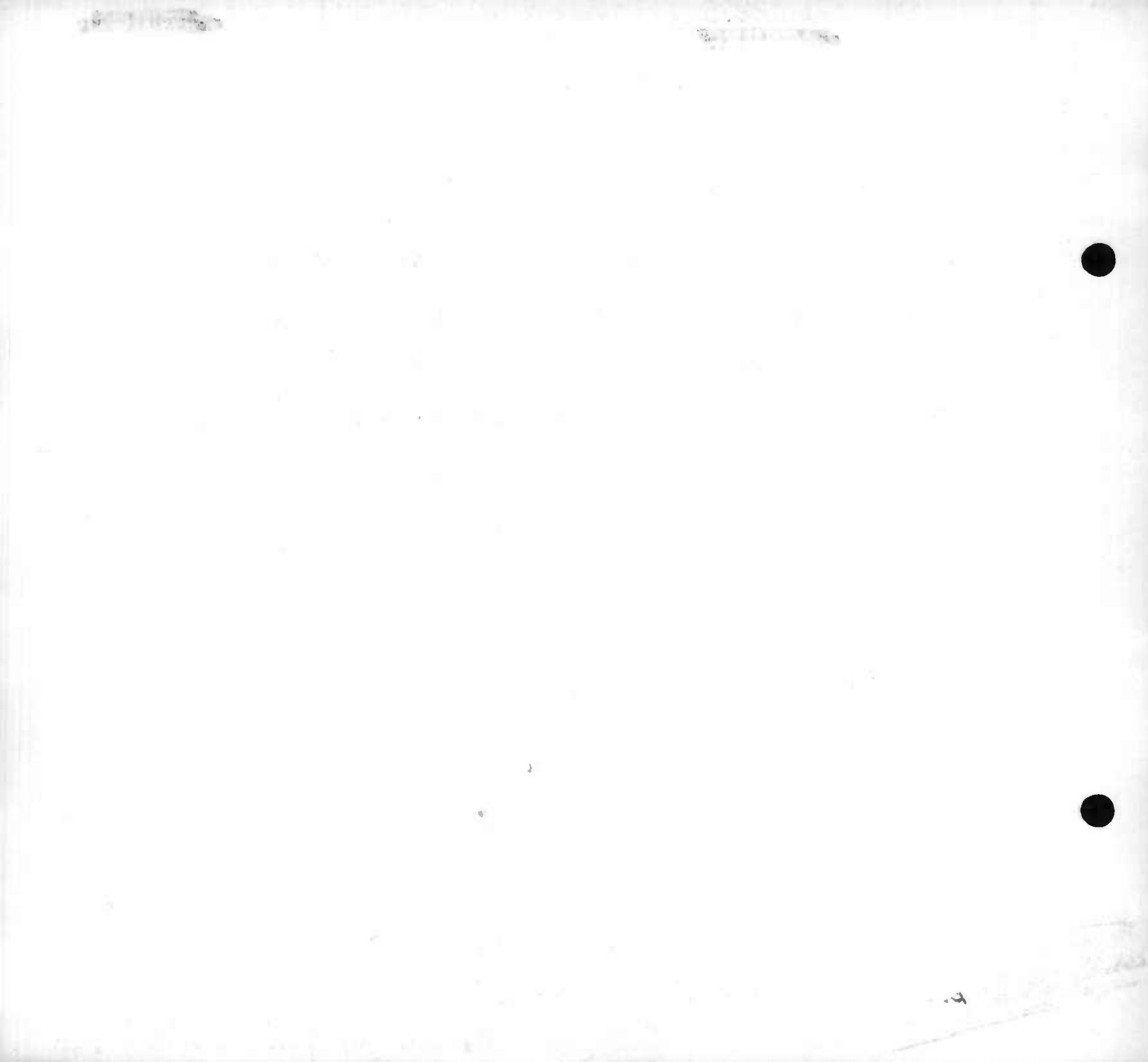
VS 150-REV. 1/1/68





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Unattended cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">71 12275</span>	
BIRTH NO. <span style="float: right;">71 12275</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>THOMPSONS WEAVER, SR.</b>		2. DATE AND HOUR OF DEATH <b>12/28/71 10:40 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>806</b>			
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>1937 E. LAFAYETTE AVE.</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/25/1900</b>	9. AGE (In years last birthday) <b>71</b>	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chain Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Brunswick Co. Va.</b>	
13. FATHER'S NAME <b>JERRY WEAVER</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-09-1591</b>		17. INFORMANT ADDRESS <b>Thompkins Weaver, Jr. 5110 Goodnow Rd. 21206</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest - Colon</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Sepsis - gm</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Ca of Colon</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Ca of Colon</b>		<b>3 weeks</b>	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>12/13/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca of Colon</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/13</b> <b>1971</b> to <b>12/28</b> <b>1971</b> that (I) (we) last saw the deceased alive on <b>12/28</b> <b>10:40</b> <b>1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  <b>JOHN CAMERON M.D.</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/28/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN CAMERON M.D.</b>		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-31-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Arbutus, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Rudolph Hollick 2431 E. Oliver St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 12276</u>	
BIRTH NO. <u>71 12276</u>		1. NAME OF DECEASED (Type or Print) <u>Carrie GREEN</u>		2. DATE AND HOUR OF DEATH <u>December 28, 1971 12:35 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90</u> <u>Midtown Home, Inc.</u> <u>808 St. Paul Street</u> <u>Baltimore, Maryland 21202</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>909</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1312 N. Caroline St</u>		
5. SEX <u>F</u>	6. RACE <u>B</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/1913</u>	9. AGE (In years last birthday) <u>58</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
13. FATHER'S NAME <u>Sherman Parsons</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-2498</u>		17. INFORMANT <u>Collin J. Green 1312 N. Caroline St.</u>	
18. <u>412.41</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>C.V.A.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>A.S.C.V.D.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Arteriosclerosis</u>			<u>?</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19 June</u> <u>1970</u> to <u>December 28</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>12/21</u> <u>1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph S. Blum</u>				23B. DATE SIGNED <u>12/29/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM</u>		23D. ADDRESS <u>1115 K. CALVERT ST.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-31-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION (City, town, or county) <u>Arbutus Maryland</u>		(State) <u>Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 7 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>Rodolph J. Collick 2431 E. Oliver St.</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">12271</span>	
71 12277				CERTIFICATE OF DEATH	
BIRTH NO. <span style="float: right;">12277</span>		1. NAME OF DECEASED (Type or Print) <u>Smart - Amelia</u>		2. DATE AND HOUR OF DEATH <u>12-30-71</u> <u>1:30 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>Bolton Hill Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bolton Hill Nursing Home</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>B</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-1-1896</u> 9. AGE (in years last birthday) <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Hampton, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Smith</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Gray</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>267-30-7292</u>	
17. INFORMANT <u>Mrs Nellie Rogers</u>		ADDRESS <u>1312 N. Broadway</u>		18. CAUSE OF DEATH <u>470.91</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
ANTECEDENT CAUSES		(B) <u>Arteriosclerosis generalized</u>		<u>years</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>Diabetes</u>		<u>years</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>12/30/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/6</u> 19 <u>68</u> to <u>12/30</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/30</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>12/31/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Alan H. MacInt MD</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>1-3-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Md. National Park</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 7 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. J. [Signature]</u>		25C. FUNERAL DIRECTOR <u>Randolph Conlick</u> ADDRESS <u>2431 E. Oliver St.</u>	

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71 12278  
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>BENJAMIN BEN COX</b> Ben Cox		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 26 71 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 26 71 12:40a M.	
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>802</b>
9. DATE OF BIRTH <b>12-25-1899</b>	10. AGE (In years last birthday) <b>72</b>	E. STREET AND NUMBER <b>1618 N. Milton Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>N.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13. FATHER'S NAME <b>UNKNOWN</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Glass Co.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>242-42-5764 A</b>	15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>
19. <b>185 X 1</b>		18. INFORMANT <b>Mrs Helen Cox 1618 N. Milton Ave.</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of the prostate with metastasis</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>12 26 71</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>12/26/71</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park Arbutus, Md.</b>		24D. LOCATION (City, town, or county) (State) <b>10d.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. J. [illegible] M.D.</b>	
25C. FUNERAL DIRECTOR <b>Rudolph J. Collick</b>		ADDRESS <b>2431 E. Oliver St.</b>	

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1 **R-152** **71 12279** BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. **71 12279**

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		THELMA ROBINSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour		12 13 1971 6:55a M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY	
100 614 Collett St.						Md. 1501	
6. SEX female	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 1-10-33	10. AGE (In years lost birthday) 39	11. BIRTHPLACE (State or foreign country) NORFOLK VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES C. ROBINSON	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. UNKNOWN		18. INFORMANT ROSA MOSES 812 BETH VEST S.E. WASH.			
19. 2821		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Sickle cell disease DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-13-71	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-18-71		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Cedarhill Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Wesley Davis Jr. 1922 E. Howard Ave.		ADDRESS	

1-13-1972 Letter from - Office of the Chief Medical Examiner, Russell S. Fisher, M.D.  
Chief Medical Examiner

HRS

REG. NO

VS ISI-REV. 7/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

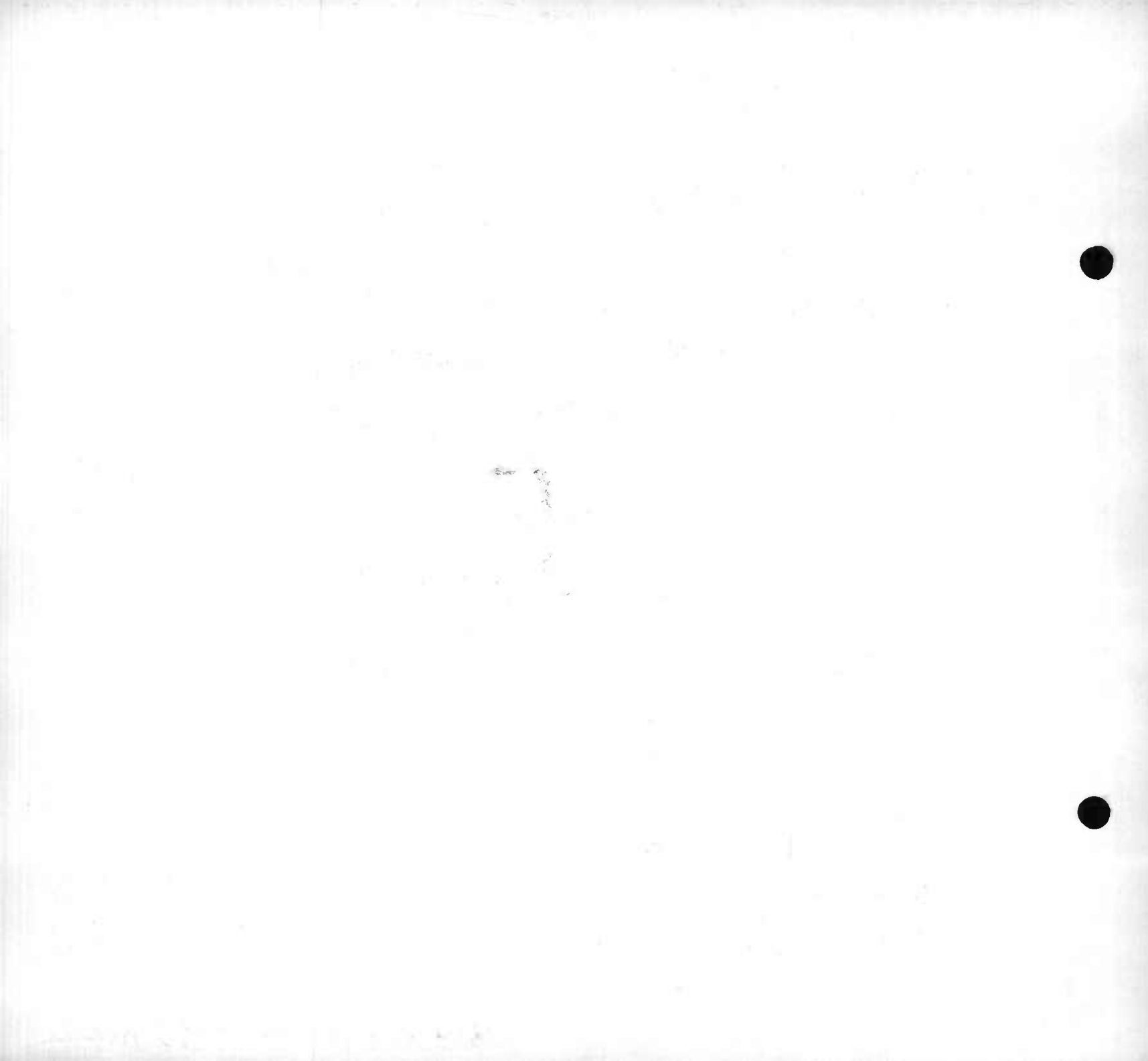
D-151		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12281	
71 12281		CERTIFICATE OF DEATH		X	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>William E. Davenport</i>		2. DATE AND HOUR OF DEATH <i>12/24/71</i> <i>6<sup>30</sup> P.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>99 Mt Sinai Nursing Home</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>HOWARD</i>		C. CITY OR TOWN <i>Waterloo</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>M</i> 6. RACE <i>C</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 13, 1889</i> 9. AGE (In years lost birthday) <i>82</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Northumberland Va</i>	
13. FATHER'S NAME <i>James Davenport</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Benns</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>227-07-6678</i>		17. INFORMANT <i>Clinton Davenport</i>	
18. <i>185 X I</i>		CAUSE OF DEATH		ADDRESS <i>7310 Wye Ave</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of Prostate</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 19</i> 19 <i>71</i> to <i>12/24/71</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>12/24</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E. S. Kallins MD</i>		23B. DATE SIGNED <i>1/3/72</i>		23C. PHYSICIAN'S NAME (Type) <i>E. S. KALLINS MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-28-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Shiloh Baptist Ch. Cem</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 7 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Hall, Jr.</i>		25C. FUNERAL DIRECTOR <i>Joseph A. Rums</i>	
25D. ADDRESS <i>6000 PARK H B A BALTIMORE MD</i>		25E. ADDRESS <i>2222 W. North Ave</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">71 12282</span>	
CERTIFICATE OF DEATH					
BIRTH NO. <span style="font-size: 1.2em;">1-5025</span>		71 12282			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">JOHNSON, MINNIE</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12-26-71</span> <span style="font-size: 1.2em;">7 PM</span> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">PROVIDENT HOSPITAL BALTIMORE Md 21216</span>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.2em;">1403</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">2127 ETTING ST.</span>		
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">NW</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">8/21/78</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">93</span>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">N/A</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Md. U. S. A.</span>
12. CITIZEN OF WHAT COUNTRY <span style="font-size: 1.2em;">U. S. A.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">GEORGE JOHNSON</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Lillian Mary Catherine Felten</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-03922</span>			17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Truman Dorsey 1802 Presman St</span>		
18. <span style="font-size: 1.2em;">410.9 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the underlying condition last.			CAUSE OF DEATH <span style="font-size: 1.2em;">ACUTE INFERIOR MYOCARDIAL INFARCTION</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Congestive Failure</span> (C) <span style="font-size: 1.2em;">Pulmonary Edema</span>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">5 HOURS</span>  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">N/A</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <span style="font-size: 1.2em;">11-29-1971</span> to <span style="font-size: 1.2em;">12-26-1971</span> that (1) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12-25-1971</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Richard Tyson, M.D.</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">12-26-71</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">RICHARD TYSON, M.D.</span>			23D. ADDRESS <span style="font-size: 1.2em;">936 W. NORTH AV. BALTIMORE 21217 Md.</span>		
24A. BURIAL CREMATION, REMOVAL <span style="font-size: 1.2em;">B</span>		24B. DATE <span style="font-size: 1.2em;">12/29/71</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Mt Auburn</span>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 7 1972</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Joseph E. Run</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">2222 N. North Ave</span>			

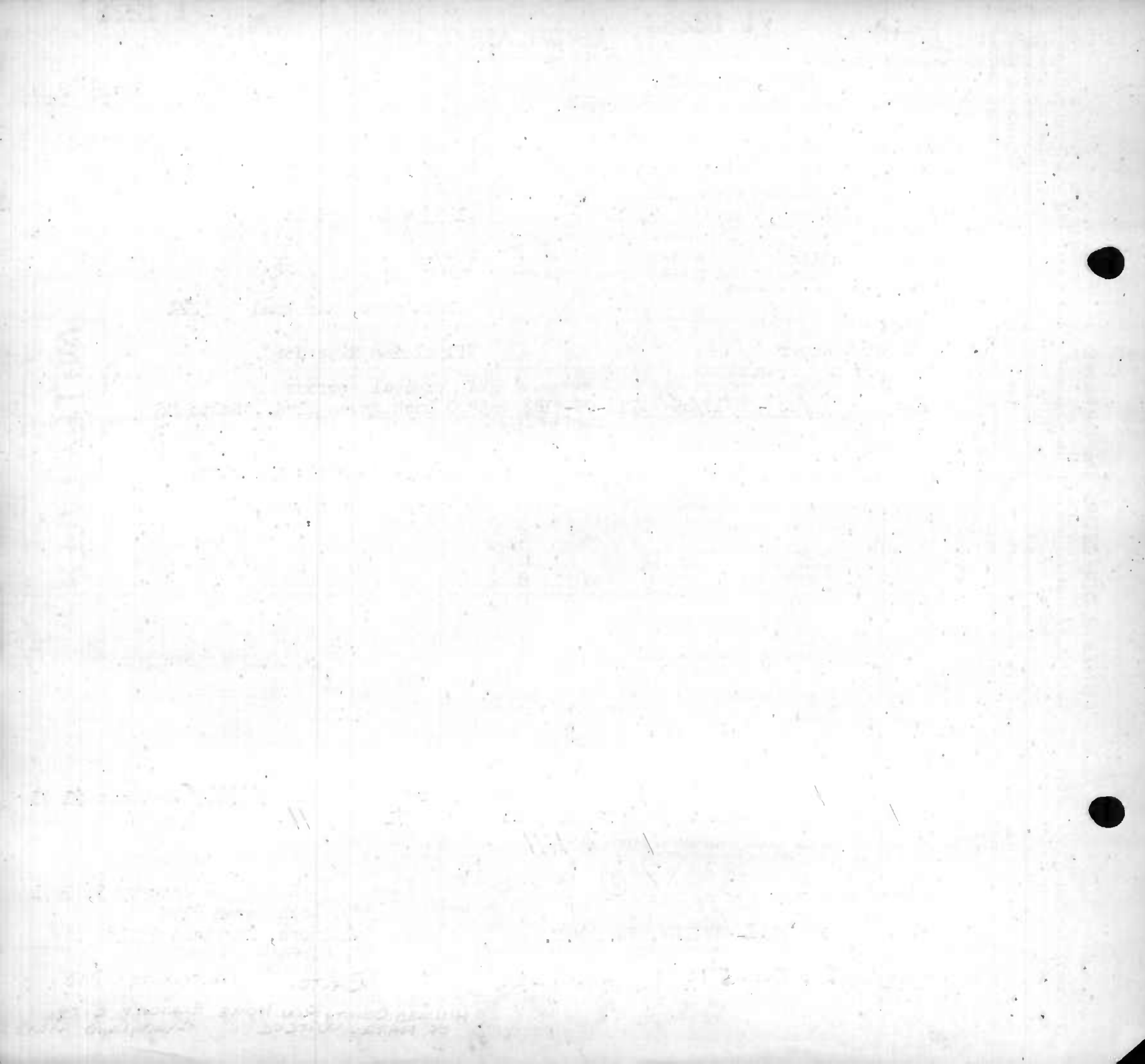




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

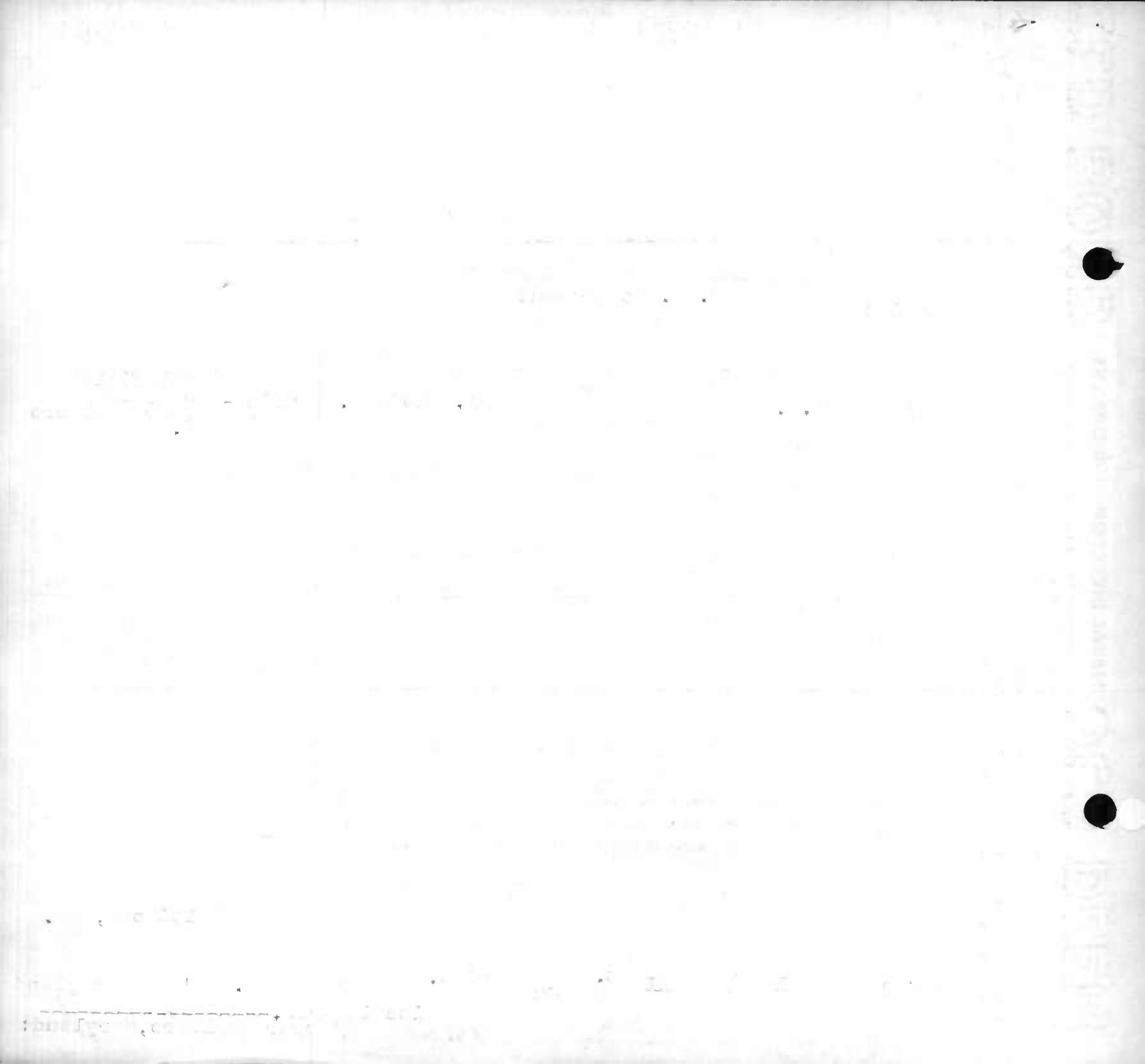
K-560 71 12283		BALTIMORE CITY HEALTH DEPT CERTIFICATE OF DEATH		71 12283 REG. NO.
1. NAME OF DECEASED (Type or Print) <b>KNORR, WILLIAM F</b>		2. DATE AND HOUR OF DEATH <b>December 31, 1971 10:15 P M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1903</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1835 W Lombard St</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/5/16</b>	9. AGE (In years last birthday) <b>55</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Ernest A Knorr</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmina Ringsdorf</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 2/9/42 - 6/17/45</b>		16. SOCIAL SECURITY NO. <b>218-05-2188</b>		17. INFORMANT <b>VA Hospital Records</b> ADDRESS <b>3900 Loch Raven Blvd., Balto Md</b>
18. <b>44191</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>Rupture Aortic aneurism</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <b>1</b> (this hospital) attended the deceased from <b>October 3rd 1971</b> to <b>January 3rd 1972</b> , that <b>1</b> (we) last saw the deceased alive on <b>December 31st 1971</b> and that in <b>1</b> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>1</b> (We) (did) <b>not</b> view the body after death.				
23A. SIGNATURE <b>Antonio Gonzalez - Revilla, Jr., M.D.</b>		23B. DATE SIGNED <b>January 3, 1971</b>		23C. PHYSICIAN'S NAME (Type) <b>ANTONIO GONZALEZ-REVILLA, JR., M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>JAN. 5, 72</b>		24C. NAME OF CEMETERY or CREMATORY <b>LOUDON PARK</b>
24D. LOCATION <b>BALTO.</b>		24E. CITY, TOWN, or county <b>BALTO. CITY, MD.</b>		24F. STATE <b>MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>Howard County Fun. Home</b>		25C. FUNERAL DIRECTOR <b>OF HARDY WITZKE</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

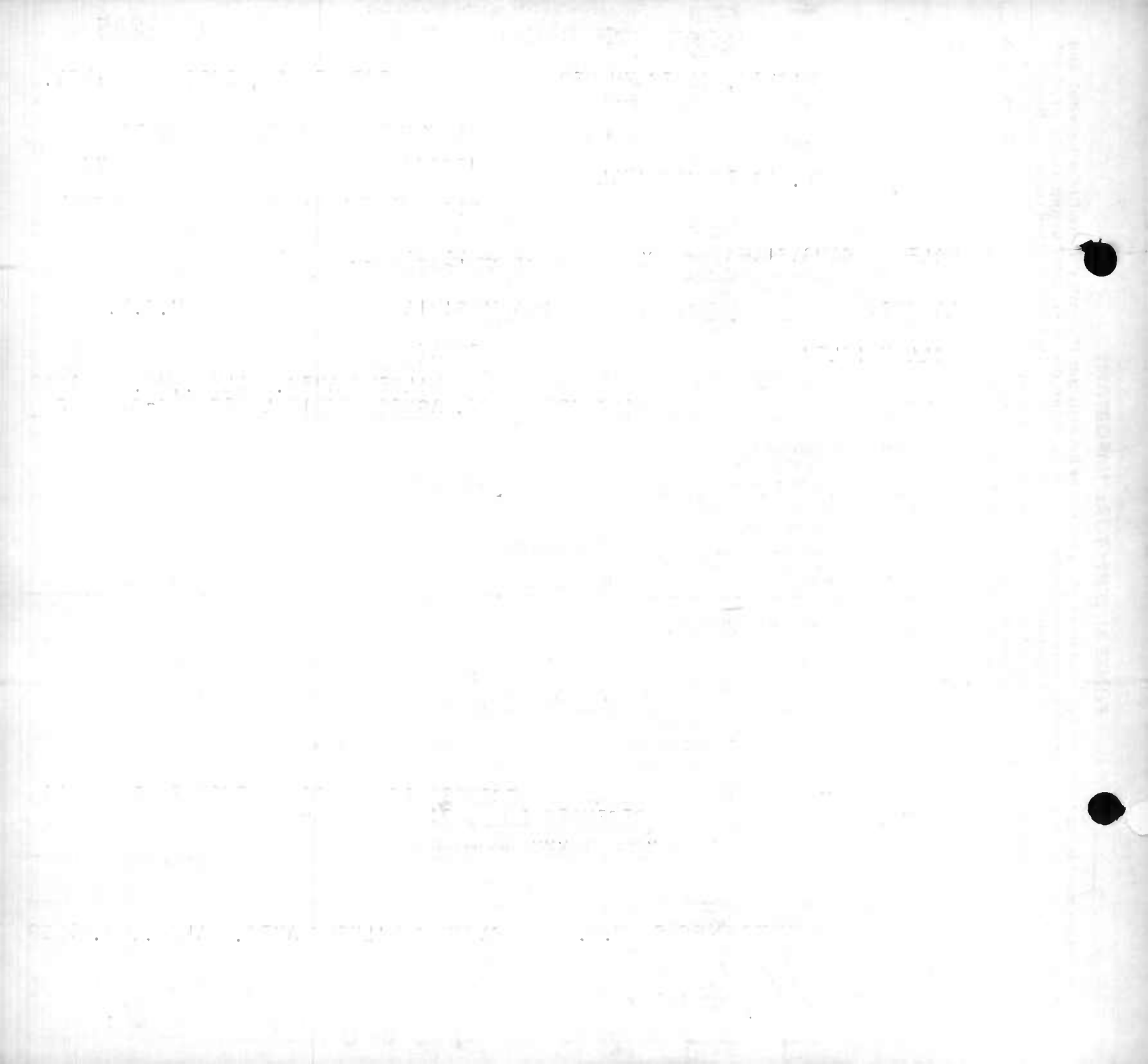
B-452		71 12284		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12284	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BOWLING JOHN D. JR</b>				2. DATE AND HOUR OF DEATH <b>Dec. 30. 71 12:10 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>P.G.</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>				IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <b>UPPER MARLBORO</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>03-27-95</b>		9. AGE (In years last birthday) <b>76</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U. S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>JOHN D. BOWLING</b>				14. MOTHER'S MAIDEN NAME <b>Mildred NAILE</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. I</b>		17. INFORMANT <b>Mrs. Rhoda C. Bowling-</b>			18. <b>Bellfield</b> <b>Box 3800</b> <b>Upper Marlboro Md.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH <b>15-3.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMATOSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CA. of colon</b>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>12-24-71</b> 19 to <b>12-30-71</b> 19 that (I) (we) last saw the deceased alive on <b>12-30-71</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>[Signature]</b>				DEGREE <b>MD</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-30-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAIRO RANIERZ</b>		DEGREE <b>MD</b>		23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b> <b>Baltimore, Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/2/72</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Thomas Episc. Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Croom Pr. Geo's Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 10 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>Ritchie Bros.</b>		ADDRESS <b>Upper Marlboro, Maryland</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <b>71 12285</b>	
<b>BIRTH NO.</b> <b>K-524</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>KNISLEY, JAMES TURNER</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>DECEMBER 30, 1971</b> <b>2:45A.M.</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>40 ST. AGNES HOSPITAL</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution residence before admission) <b>A. STATE</b> <b>MARYLAND</b> <b>B. COUNTY</b> <b>HOWARD</b> <b>20794 6300</b> <b>C. CITY OR TOWN</b> <b>JESSUP</b> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>7150 MONTIVEDO ROAD</b> <b>20794</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. RACE</b> <b>CAUCASIAN</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>09 13 92</b>	<b>9. AGE</b> (In years last birthday) <b>79</b>	<b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>STATE OF MD</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>VIRGINIA</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>WILL KNISLEY</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>EMMA ( ) LICHLITER</b>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>217505780</b>		<b>17. INFORMANT</b> <b>WILKENS AVES. BALTO., MD. 21229</b> <b>ST. AGNES HOSPITAL RECORDS-CATON &amp;</b>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <i>Bronchogenic Carcinoma</i> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>NO</b>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (X) (this hospital) attended the deceased from</b> <b>DECEMBER 15</b> <b>19 71</b> <b>to</b> <b>DECEMBER 30</b> <b>19 71</b> <b>that (X) (we) last saw the deceased alive on</b> <b>DECEMBER 30</b> <b>19 71</b> <b>and that in (Xy) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (X) (We) (did) (d)(X)(y) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>Donato A. Vargas</i>				<b>23B. DATE SIGNED</b> <b>12-30-71</b>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>DONATO VARGAS M.D.</b>				<b>23D. ADDRESS</b> <b>CATON &amp; WILKENS AVES. BALTO., MD. 21229</b>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>1/1/72</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Madamidge Memorial Park</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Darkey Maryland</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 12 1972</b>			
<b>25B. NAME OF REGISTRAR</b> <i>[Signature]</i>		<b>25C. FUNERAL DIRECTOR</b> <i>[Signature]</i>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES CHASE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour December 31, 1971 1:11 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9/5/52		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 19 If Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 1916 W. Saratoga Street	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Chase		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Long shoreman	
15. MOTHER'S MAIDEN NAME Katie Hall		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 212-56-5835		18. INFORMANT ADDRESS Richard A. Chase, 1916 Saratoga St.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E965X Gunshot wound of abdomen		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 500 Block N. Payson Street 1604	
22D. TIME OF INJURY (APPROX.) 12-30-71 11:45 P. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Shot during altercation		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 12/31/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/72	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 14 1972		25B. NAME OF REGISTRAR Kenneth Law	
25C. FUNERAL DIRECTOR Kenneth Law		ADDRESS 4611 Park Heights Ave.	





## CERTIFICATE OF DEATH

REG. NO.

71 12287

BIRTH NO. 71-21770

1. NAME OF DECEASED

(Type or Print)

Baby Boy [REDACTED] Cramer

2. DATE AND HOUR OF DEATH

December 29, 1971

10:25 A.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

13 South Kresson 21224

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-27-71

9. AGE (In years last birthday)

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Mary Jane

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH: Records Baltimore, Maryland 21224

18. 776-21

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

HYPOXIA ACIDOSIS

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) RESPIRATORY DISTRESS

DUE TO, OR AS A CONSEQUENCE OF:

(C) PREMATUREITY

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

6 HRS.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

ANEMIA, HYPONATREMIA

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/27 1971 to 12/29 1971

(that (I) (we) last saw the deceased alive on 12/29 1971 and that (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

B. Zetelli

DEGREE

Attending Phys. ☒Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

12/29

23C. PHYSICIAN'S NAME (Type)

B. Zetelli, M.D.

23D. ADDRESS

DEGREE

Baltimore City Hospitals

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

12-31-71

24C. NAME OF CEMETERY OR CREMATORY

Baltimore City Hospitals

24D. LOCATION

(City, town, or county)

Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.

JAN 17 1972

25B. NAME OF REGISTRAR

Robert E. [REDACTED]

25C. FUNERAL DIRECTOR

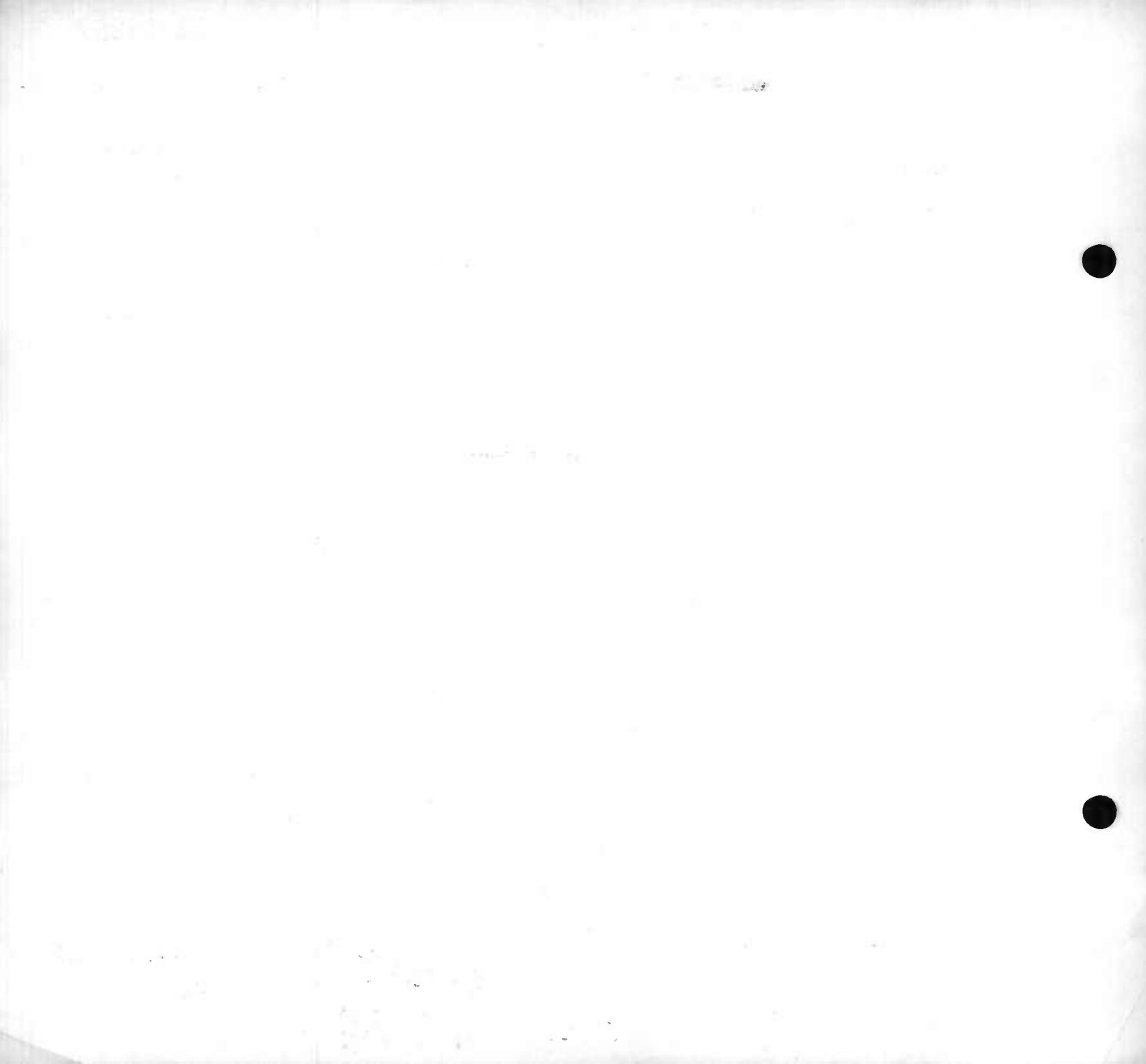
[REDACTED]

ADDRESS

HOSPITAL DISPOSAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



BIRTH NO.

VS 151-REV. 3/1/68

1888

1888

1888



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
HOWARD HOANEY		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
00 616 Springfield Ave.		11 22 1971 6:45 a.m.		Md. 2710		10. AGE (In years last birthday) 65		E. STREET AND NUMBER 616 Springfield Ave.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
41221		Hypertensive cardiovascular disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATOR		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS			
JAN 17 1972		Russell S. Fisher, M.D.		11-22-71		ANATOMY BOARD OF MARYLAND		UNIVERSITY MEDICAL SCHOOL	
VS 151-REV. 7/1/68						MORTUARY SERVICE - BCHD			

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U-525-71 12290 BALTIMORE CITY HEALTH DEPARTMENT 71 12290

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. REG. NO.

1. NAME OF DECEASED (Type or Print) <u>UNIDENTIFIED</u>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>619 Pierce Street</u>		3. DATE PRONOUNCED DEAD Month Day Year Hour <u>September 1, 1971</u> <u>1:55 P.</u> M.	
6. SEX <u>Male</u>		7. RACE <u>Negro</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>0000</u> B. COUNTY <u>0000</u>	
9. DATE OF BIRTH		10. AGE (In years last birthday) <u>60</u> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. STREET AND NUMBER	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. <u>796.7</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH UNDETERMINED (due to advanced post mortem decomposition) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Charles S. Springate</u> Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 11, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1-13-72</u>	
24C. NAME OF CEMETERY or CREMATOR		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 17 1972</u>		25B. NAME OF REGISTRAR <u>Robert J. [unclear]</u>	

VS 151-REV. 7/1/68

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD



1891 15

STANDARD INDUSTRIAL PAPER CO.

MADE IN U.S.A.

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U-52571 12291

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12291

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>( UNIDENTIFIED )</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Found flating in water off 2700 block Boston Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 14, 1971 5:05 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>?</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) <b>60 ?</b>		E. STREET AND NUMBER	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY <b>00-00</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

19. <b>E9841 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Found in water, presumably drowned</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (b) DUE TO, OR AS A CONSEQUENCE OF:  (c) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					

20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>?</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>?</b>	
22D. TIME OF INJURY (APPROX.) <b>?</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>?</b>	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> January 11, 1972	

24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-13-72</b>		24C. NAME OF CEMETERY OR CREMATORY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
24D. LOCATION (City, town, and county)		24E. LOCATION (State)		24F. LOCATION (State)	

JAN 17 1972 Robert E. Fisher, M.D.

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL

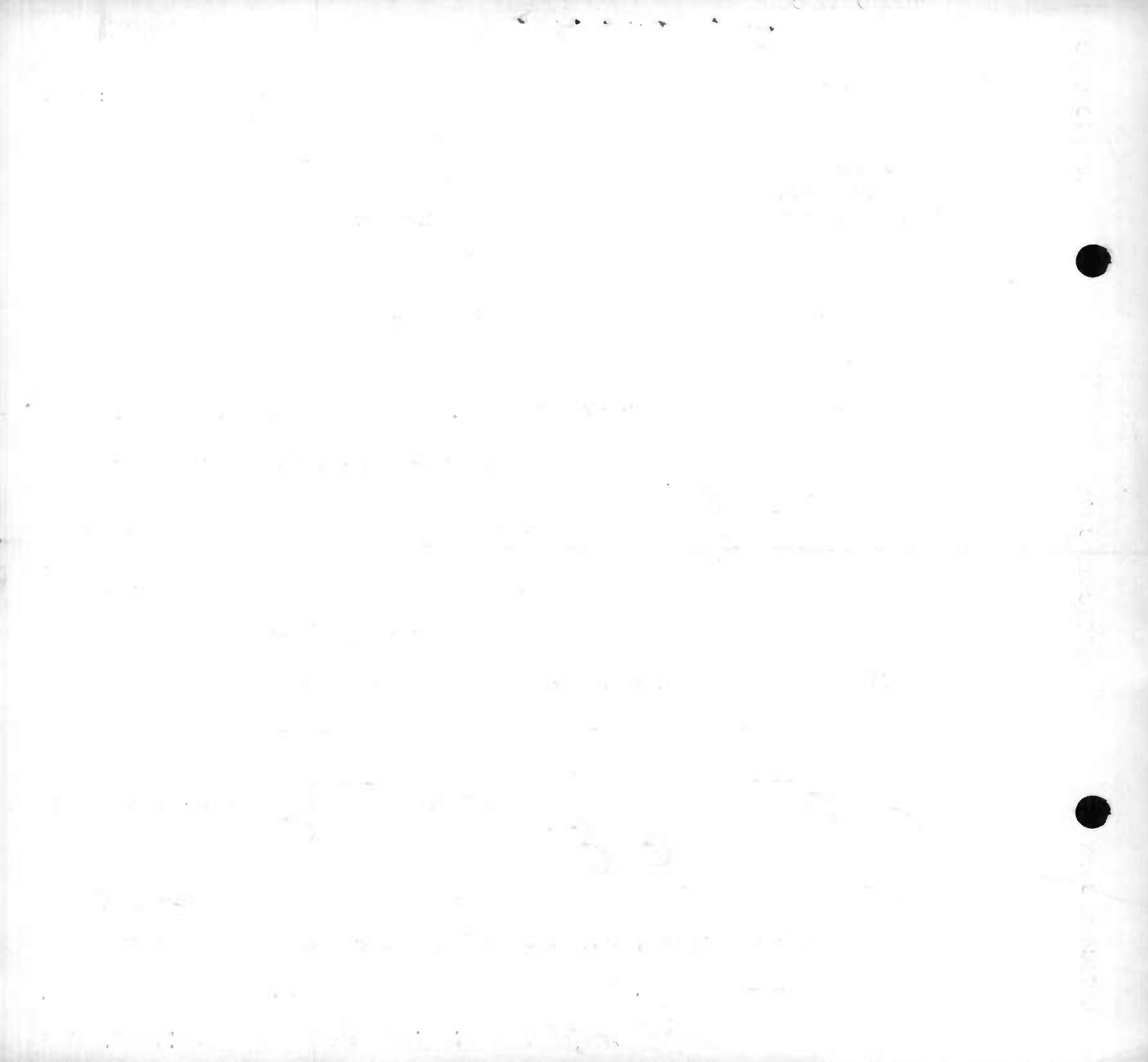
MORTUARY SERVICE - BCSD

PROPERTY BOOK

DUPLICATE COPY  
FUNERAL DIRECTOR: IMPORTANT  
DUPLICATE COPY

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12292	
BIRTH NO. 71 12292		1. NAME OF DECEASED (Type or Print) Margaret M. LEMKE		2. DATE AND HOUR OF DEATH December 29, 1971 11:05 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2778		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Key Circle Hospice 1214 Eutaw Place Baltimore, Maryland 21217		E. STREET AND NUMBER 611 St. Dunstons Road			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/1892	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Christolf Hucke		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-48-7568		17. INFORMANT ADDRESS Mr. Edward Lemke, Jr. 611 St. Dunstons Rd.	
18. 461,014-5887X CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This section is to be completed by the medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Deep thrombophlebitis right leg		hours	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Acute pulmonary embolism		months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) Fracture right femur		CVA with residual paralysis	
19A. DATE OF OPERATION 6/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture Femur		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ---		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) My Aunt's	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX) 6-20-71		21E. INJURY OCCURRED While At Work <input type="checkbox"/> -- Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fall	
22. I certify that (1) (this hospital) attended the deceased from July 21 19 70 to December 29 19 71 that (1) (we) last saw the deceased alive on Dec. 29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dionisio Garcia, Jr., M.D.				23B. DATE SIGNED 1/18/72	
23C. PHYSICIAN'S NAME (Type) Dionisio Garcia, Jr., M.D.				23D. ADDRESS 5550 Baltimore National Pike 21228	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-3-72		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel	
24D. LOCATION Balto.		24E. CITY, town, or county Md.		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1972		25B. NAME OF REGISTRAR E. H. H. H.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 1206 York Road Balto., Md. 21212	



BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 71 12293									
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) Raymond S. Hodges					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 21 71 11:35 P.M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 811 E. Baltimore St.					3. DATE PRONOUNCED DEAD Month Day Year 12 21 71 11:35 A.M.				
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 302									
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday) 64		11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER 811 E. Baltimore Street			
		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS			
19. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
(A) IMMEDIATE CAUSE Fatty liver DUE TO, OR AS A CONSEQUENCE OF:									
(B) DUE TO, OR AS A CONSEQUENCE OF:									
(C) DUE TO, OR AS A CONSEQUENCE OF:									
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) Partial									
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?									
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 22F. HOW DID INJURY OCCUR?									
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-21-71 ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.									
24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 1-18-72 24C. NAME OF CEMETERY or CREMATOR 24D. CITY, TOWN, OR COUNTY (State)									
25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR									
JAN 25 1972 Robert E. Bailey, M.D.									
ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD									

1000

1000

M-240

71 12294

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

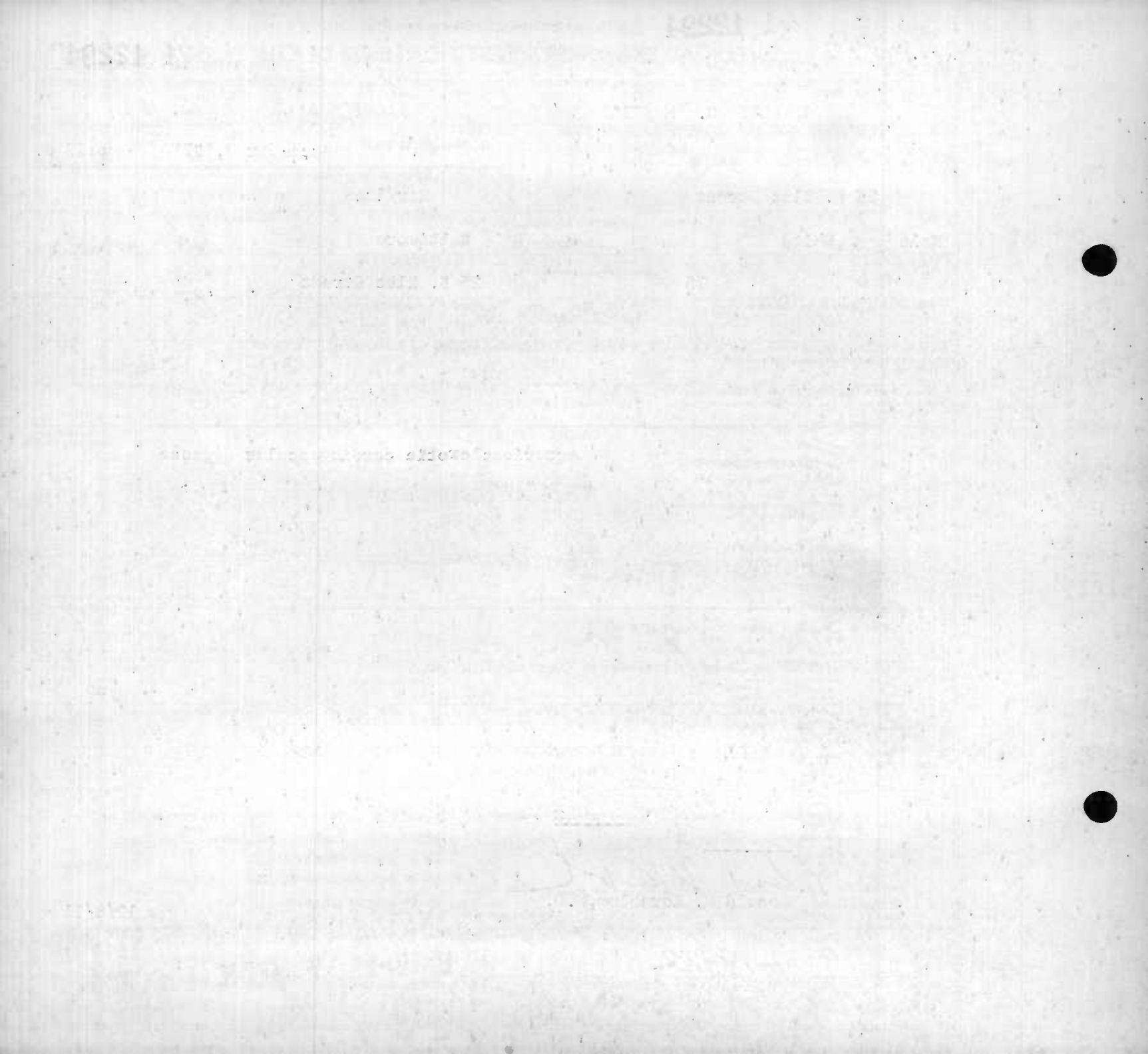
REG. NO. 71 12294

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES C. MESKILL</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 25 E. 21st Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 7, 1971</b> Hour M. <b>6:15 P.</b>	
6. SEX <b>Male</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>White</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) <b>73</b>		E. STREET AND NUMBER <b>25 E. 21st Street</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. <b>41241</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/8/71</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-18-72</b>	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, State, or County)	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>John E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR		25D. ADDRESS	

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD

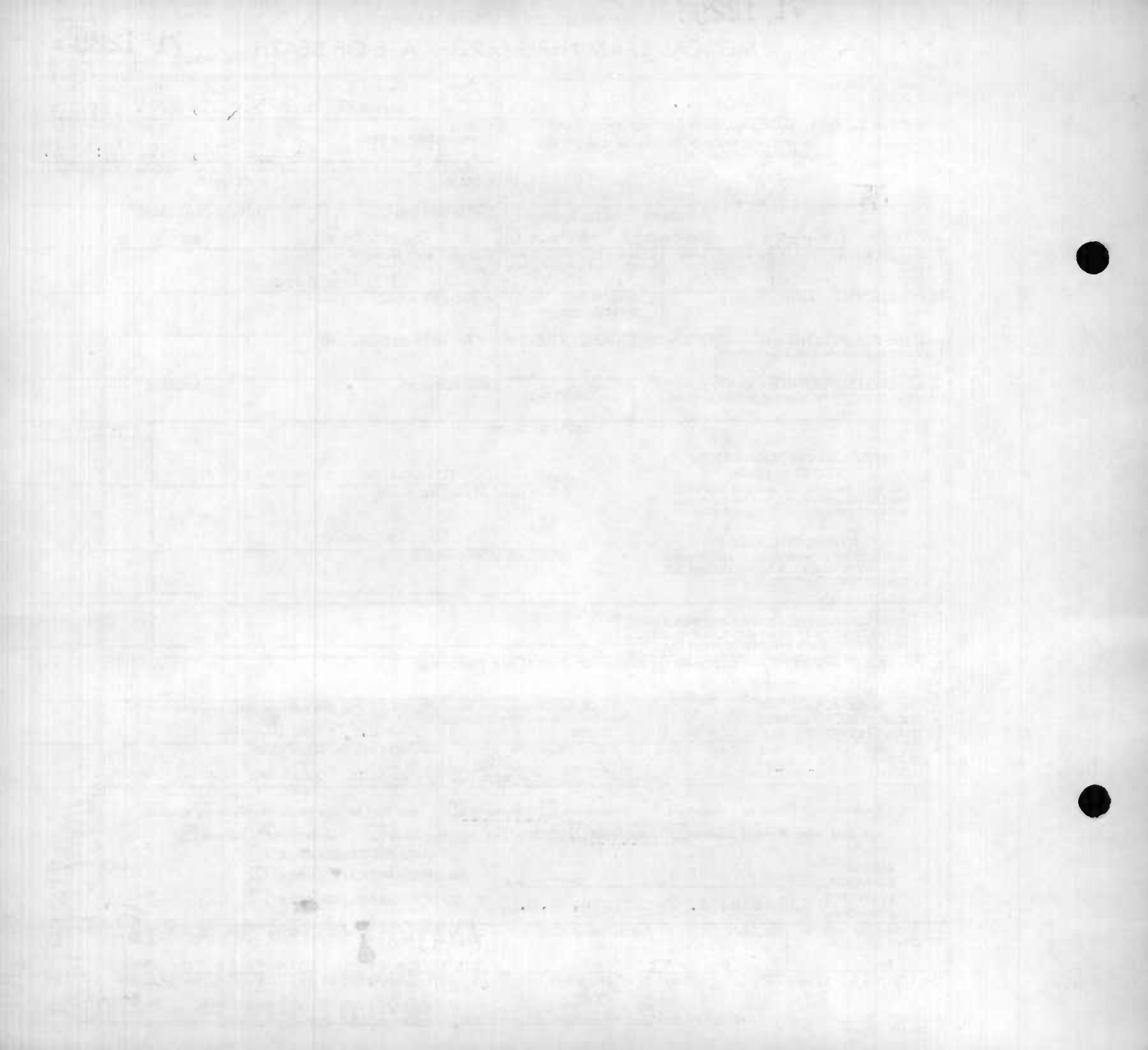




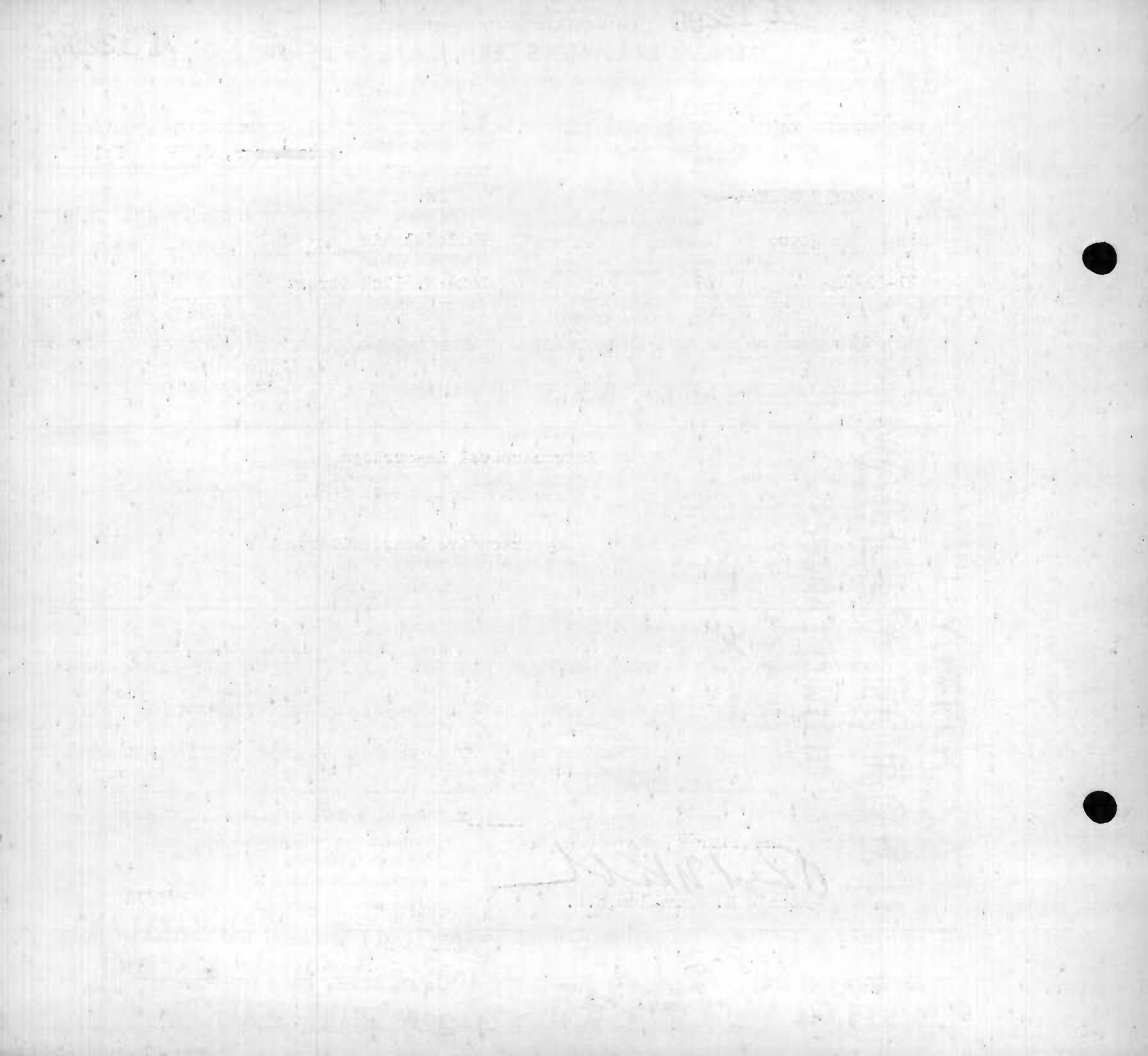


BIRTH NO.		REG. NO.	
6-652		71 12295	
BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
EDWARD J. GRENAGLE		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD	
Maryland General Hospital (DOA)		Month Day Year	
		December 12, 1971 1:45 A. M.	
6. SEX		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
Male	7. RACE	A. STATE	
White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. COUNTY	
	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Maryland	
		C. CITY OR TOWN	
		Baltimore	
		D. INSIDE CITY LIMITS?	
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH	10. AGE (In years lost birthday)	E. STREET AND NUMBER	
	66	840 Eutaw Street	
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		Home	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED	
12-11-71		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23.		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
		840 N. Eutaw Street	
		22F. HOW DID INJURY OCCUR?	
		Subject found on second floor of burning building	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No)	
ACTUAL SIGNATURE		Yes	
EXAMINER'S NAME (Type)			
Charles S. Springate, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
		1-18-72	
24C. NAME OF CEMETERY or CREMATOR		24D. LOCATION	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
JAN 25 1972		Charles S. Springate, M.D.	
25C. NUMERAL DIRECTOR		25D. ADDRESS	

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD



BALTIMORE CITY HEALTH DEPARTMENT				71 12296			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 12296			
1. NAME OF DECEASED (Type or Print) <b>WILLIAM HOPKINS</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF UNDER 1 YR. IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 MERCY HOSPITAL</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>November 9, 1971 3:18 P.</b>			
6. SEX <b>Male</b>				7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>11-13-23</b>				10. AGE (In years last birthday) <b>47</b>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Pa.</b> B. COUNTY <b>V35</b>	
15. MOTHER'S MAIDEN NAME				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT				ADDRESS			
19. <b>402 X 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Intracerebral Hemorrhage</b>				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. DATE OF OPERATION				21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME (Month) (Day) (Year) (Hour) (Approx.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Ronald N. Kornblum, M.D.</b> EXAMINER'S NAME (Type) DATE SIGNED: <b>1/5/72</b>				24A. BURIAL CREMATION, REMOVAL (Specify)			
24B. DATE <b>1-18-72</b>				24C. NAME OF CEMETERY or CREMATOR			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>				25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>			
25C. FUNERAL DIRECTOR				25D. ADDRESS			



71 12297

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12297

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>AJAY WARD</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>December 23, 1971</b>		Month Day Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 23, 1971</b>		Hour <b>8:10 A.</b>	
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1403</b>					
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH		10. AGE (In years last birthday) <b>49</b>	11. BIRTHPLACE (State or foreign country)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER <b>1820 Etting Street</b>			
13. FATHER'S NAME		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. <b>1621 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Carcinoma of lung</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>12/23/71</b>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-18-72</b>		24C. NAME OF CEMETERY <b>ANATOMY BOARD OF MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>UNIVERSITY MEDICAL SCHOOL</b>	
				25D. ADDRESS <b>MORTUARY SERVICE - BCHD</b>	

TEST 10

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S-421

71 12298

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12298

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>LEON SALISBURY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 311 S. Sharp St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 26 1971 9:06 a.m.</b>	
6. SEX <b>male</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>negro</b>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2201</b>	
9. DATE OF BIRTH		10. AGE (In years last birthday) <b>60</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>291.9 I</b>		CAUSE OF DEATH <b>Chronic alcoholism with psychotic manifestations</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) <b>yes</b>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12-27-71</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-21-72</b>	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	



1-27-1972 - Letter from - Office of the Chief Medical Examiner, Russell S. Fisher, M.D.  
Chief Medical Examiner

HRS



J-525 71 12299

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12299

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Edward Johnson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 13 Year 71 Hour 3:26 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1023 Race Street		3. DATE PRONOUNCED DEAD Month 12 Day 13 Year 71 Hour 3:26 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2301	
9. DATE OF BIRTH 10. AGE (In years last birthday) 60?		C. CITY OR TOWN Baltimore	
11. BIRTHPLACE (State or foreign country)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 1023 Race Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. FATHER'S NAME	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-14-71			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-21-72	
24C. NAME OF CEMETERY		24D. LOCATION (City and location county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1972		25B. NAME OF REGISTRAR Robert E. Barber, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS	

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD

1955/12

1955/12

1955/12

BIRTH NO.		71 12300		BALTIMORE CITY HEALTH DEPARTMENT		12300	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 12300			
1. NAME OF DECEASED (Type or Print) <b>Leroy Buckley</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour <b>12 25 71</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>709 W. Fayette St.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 25 71 11:30 a.m.</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>402</b>	
6. SEX <b>male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>70 ?</b>		10. AGE (In years last birthday) <b>70 ?</b>		E. STREET AND NUMBER <b>709 W. Fayette St.</b>			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS			
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <i>Peter Lipkovic</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/26/71</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-25-72</b>		24C. NAME OF CEMETERY or CREMATOR		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 31 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>		ADDRESS	

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BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71-12301  
REG. NO. 71-12801

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>LOUISE BROWN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> _____ M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1305 N. Stricker St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>November 12, 1971 12:30 P.M.</b>	
6. SEX <b>Female</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>Negro</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH 10. AGE (In years last birthday) <b>86</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER <b>1305 N. Stricker St.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

19. <b>4124</b> CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
21. AUTOPSY? (Yes or No) <b>No</b>		
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		
22D. TIME OF INJURY (Approx.) Month ( ) Day ( ) Year ( ) Hour ( )		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
22F. HOW DID INJURY OCCUR?		
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>11-13-71</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>2-1-72</b>
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT <b>FEB 2 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCDH





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 0-520 71 12302				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71-12302	
1. NAME OF DECEASED (Type or Print) <b>EVA C. OWENS</b>				2. DATE AND HOUR OF DEATH <b>10 A.M. 12-25-71</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Kewson Nursing Home 2932 Arundel Ave</b>				A. STATE <b>Baltimore</b>		B. COUNTY <b>Home</b>	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3901 Carlisle Ave 1509</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-20-1898</b>	9. AGE (in years last birthday) <b>73</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Laura Morris</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>MA 715715</b>		17. INFORMANT <b>Unknown</b>		
			ADDRESS <b>Mrs. Kennedy in charge. 2922 Branch Ave</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>412-21</b>				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive C.V. Disease many months</b>			
				(B) <b>possible Pericarditis many months</b>			
				(C) <b>Senile deterioration many months</b>			
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Senile deterioration</b>							
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1, 1971</b> to <b>Dec. 25, 1971</b> and that (I) (we) last saw the deceased alive on <b>Dec. 25, 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Frank N. Ogden M.D.</b>				23B. DATE SIGNED <b>Jan. 25, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>FRANK N. OGDEN M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Airy Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Neaport (Baltimore) Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>FEB 15 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>James H. Rhee</b>		ADDRESS <b>2222 W. North Ave.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

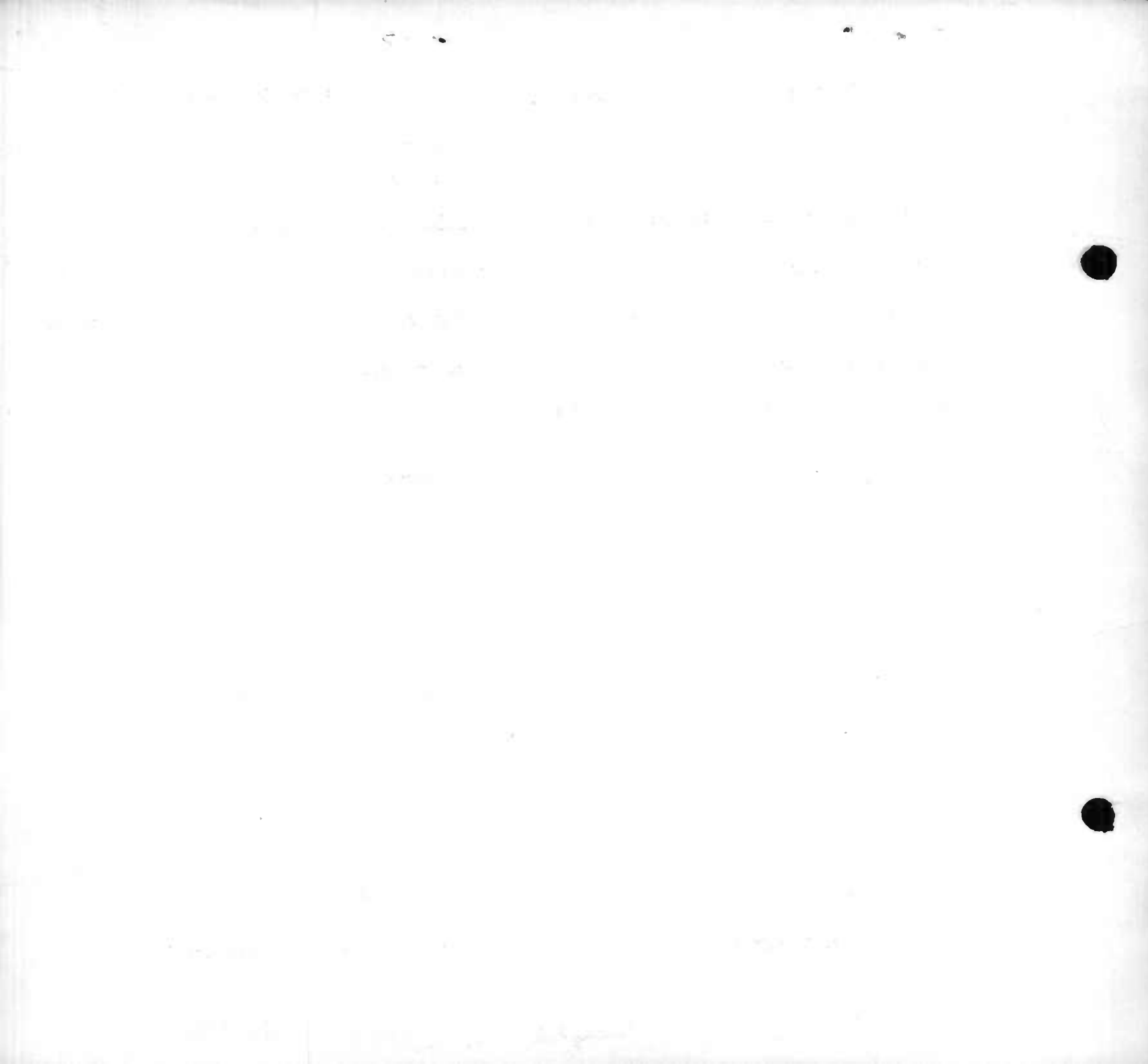
BIRTH NO. <span style="font-size: 1.5em;">B-534</span> <span style="font-size: 1.5em;">71-70634</span> <span style="font-size: 1.5em;">12303</span>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="font-size: 1.5em;">71 12303</span>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Baby Girl Bentley				12-12-71 3:50PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Sinai Hospital of Baltimore, Inc.				Maryland Balto 5300			
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH		9. AGE (in years lost birthday)	
girl C				12-10-71		2 days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
						Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Homer Bentley				Patricia Lengly			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		2 days	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 12-10-71 19 to 12-12 1971 that (I) (we) last saw the deceased alive on 12-12 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Immy Wattanasakul				12-12-71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
SOMSONG WATTANASAKUL MD				Sinai Hospital of Baltimore, Inc.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
DISPOSAL		DEC. 1971		SINAI HOSPITAL		BALTO, MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 10 1972		Robert E. Kelly, M.D.		HOSPITAL DISPOSAL			

Hospital gave zip JS 11236. - -

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 12304</u>
BIRTH NO. <u>71-19479</u>		2. DATE AND HOUR OF DEATH <u>November 19, 1971</u>   <u>11:36AM</u> M.		
1. NAME OF DECEASED (Type or Print) <u>Female</u> <u>Green</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1511</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Sinai Hospital of Baltimore, Inc.</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital of Baltimore, Inc.</u>		E. STREET AND NUMBER <u>3732 Dolfield Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/19/71</u>	9. AGE (In years last birthday) <u>Newborn</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Clarence Howard</u>		14. MOTHER'S MAIDEN NAME <u>Brenda Green</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT ADDRESS
18. <u>777X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>IMMEDIATE CAUSE</u> <u>Immaturity</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>				
19A. DATE OF OPERATION <u>21</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>yes</u>
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) I APPROX.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>A. Gabbay</u>		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <u>Dr. Albert Gabbay</u>		23D. ADDRESS <u>Sinai Hospital of Baltimore, Inc.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>DISPOSAL</u>	24B. DATE <u>NOV. 1971</u>	24C. NAME OF CEMETERY OR CREMATORY <u>SINAI HOSPITAL</u>	24D. LOCATION (City, town, or county) <u>BALTO. Md.</u>	(State)
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1972</u>	25B. NAME OF REGISTRAR <u>Albert E. Gabbay, M.D.</u>	25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>S-364</u> <u>71-20954</u> <u>71 12305</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 12305</u>	
1. NAME OF DECEASED (Type or Print) <b>Sterling, Bo. Esmie</b>				2. DATE AND HOUR OF DEATH <b>12/15/71 8:15 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <b>Maryland</b> <b>1538</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>39</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital Complex 2600 Liberty Heights Ave. Baltimore, Maryland 21215</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3022 Garrison Blvd.</b>							
5. SEX <b>Male</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/15/71</b>	9. AGE (In years last birthday) <b>N. B.</b>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Esmie Sterling-Mother</b>		
					ADDRESS <b>Same</b>		
18. <b>772X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>IMMUNITY</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PREMATURE DELIVERY</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>12/15/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/15/71</b> 19 <b>12/15/71</b> 19 that (I) (we) last saw the deceased alive on <b>12/15/71</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Lionel G. Jackson, M.D.</b>				23B. DATE SIGNED <b>March 21, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>	
23D. ADDRESS <b>2600 Liberty Heights Ave.</b>				23E. FUNERAL DIRECTOR <b>HOSPITAL DISPOSAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>DISPOSAL</b>		24B. DATE <b>3-1971</b>		24C. NAME of CEMETERY or CREMATORY <b>PROVIDENT HOSPITAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 28 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>HOSPITAL DISPOSAL</b>		ADDRESS	

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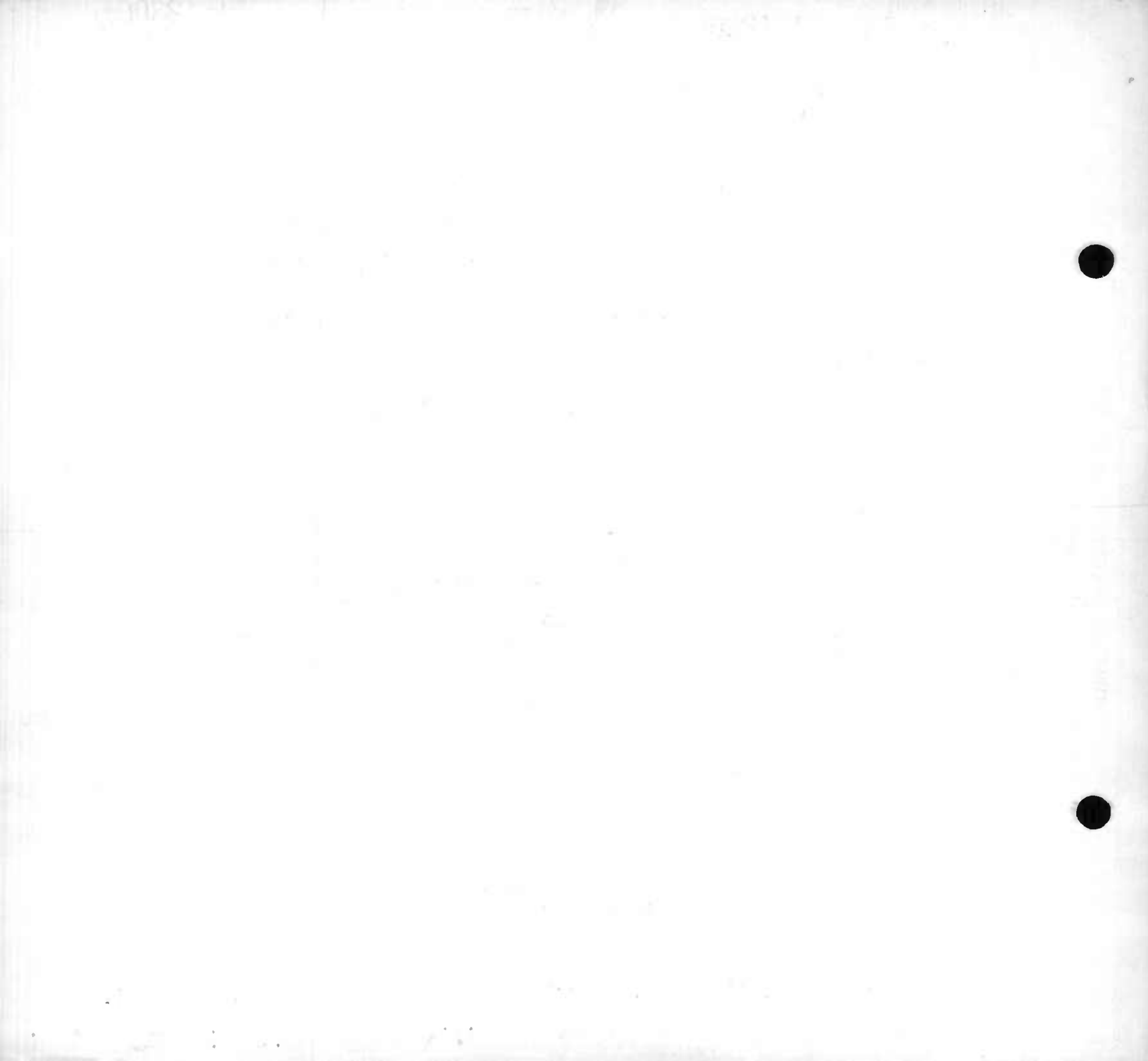
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 12306	
1-520 7171230608				REG. NO.	
BIRTH NO.				71 12306	
1. NAME OF DECEASED (Type or Print) <b>Margaret M. Lemke</b>			2. DATE AND HOUR OF DEATH <b>29 Dec. 1971 11:05 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Key Circle Hospice</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>611 St. Dunstons Rd.</b>		
5. SEX <b>F.</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/20/1922</b>	9. AGE (in years lost birthday) <b>49</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>CHRISTOLF HUKKE</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>213-48-7568</b>		
17. INFORMANT <b>EDWARD LEMKE, JR.</b>			ADDRESS <b>(SAME)</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute pulmonary embolism</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Sleep apnea (PO) deg.</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute pulmonary embolism</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Sleep apnea (PO) deg.</b> (C) <del>Chronic heart disease</del> <b>Chronic heart disease</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b> <b>Chronic heart disease</b> <b>Chronic pulmonary disease</b>					
19A. DATE OF OPERATION <b>6/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture femur</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Nursing Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Hospice Key Circle</b>	
21D. TIME OF INJURY (APPROX.) <b>6-20-71?</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>fell while walking</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>July 21 1970</b> to <b>Dec. 29 1971</b> that (I) (we) last saw the deceased alive on <b>Dec. 29 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dionisio Garcia Jr.</b>			23B. DATE SIGNED <b>1/30/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>DIONISIO GARCIA JR.</b>			23D. ADDRESS <b>5550 Baltimore North Pike 21228</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/3/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Carmel</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 3 1972</b>			
25B. NAME OF REGISTRAR <b>Dionisio Garcia Jr.</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>			
25D. ADDRESS <b>4905 York Rd. Balto., Md. 21212</b>					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 12306</u>	
<u>B-534</u> BIRTH NO. <u>71-20434</u> 1. NAME OF DECEASED (Type or Print) <u>Baby Girl Bentley</u>		<u>71-12303</u> 2. DATE AND HOUR OF DEATH <u>12-12-71</u> <u>3:50</u> p. M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Baltimore, Inc.</u>	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>BALTO</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>338 Walgrove Road</u>	
5. SEX <u>Female</u> 6. RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-10-71</u> 9. AGE (In years last birthday) <u>2 days</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Homer Bentley</u>		14. MOTHER'S MAIDEN NAME <u>Patricia Lengly</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Void</u>		ADDRESS		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Immaturity</u> <u>See D.C. 71-12303</u>	
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>Yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Void</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12-10-71</u> 19 to <u>12-12-71</u> 19 that (I) (we) last saw the deceased alive on <u>12-12-71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Samsong Wattanasakul</u> 23C. PHYSICIAN'S NAME (Type) <u>Samsong Wattanasakul, M.D.</u>		M.D. DEGREE <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-12-71</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>4-4-72</u>		24B. DATE <u>4-4-72</u>		24C. NAME of CEMETERY or CREMATORIAL SOCIETY <u>Sinai Hospital of Baltimore, Inc.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>		25B. NAME OF REGISTRAR <u>John A. ...</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>	

